July, 1960

MENTAL HYGIENE

Published Quarterly by the
National Association for Mental Health

Quarterly Journal of the

National Association for Mental Health, Inc.

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MENTAL HYGIENE

MENTAL HYGIENE aims to bring dependable information to everyone interested in mental problems. Here are original papers by writers of authority, reviews of important books, reports of surveys, special investigations and new methods of prevention and treatment in the broad field of mental hygiene and psychopathology. Our aim is to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, nurses, public officials and students of social problems find it of special value.

$6.00 a year (Canadian $6.25; foreign $6.50). Single copy $1.50. Publication office: 49 Sheridan Ave., Albany 10, N. Y. Editorial and business office: 10 Columbus Circle, New York 19, N. Y. *Second class postage* paid at Albany, N. Y.

VOLUME FORTY-FOUR, NUMBER THREE *July, 1960*

Articles

Book Reviews

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The work of the World Health Organization in the field of mental health

GENERAL INTRODUCTION

According to the Constitution of the World Health Organization, health is not simply the absence of disease but "a state of complete physical, mental and social well-being." It was natural, therefore, that a unit for mental health should be set up when the organization began its work. In January, 1949, this unit started functioning at the headquarters of the organization in Geneva. In the beginning, its staff was limited to one professional person. Since then, the staff has been slowly increasing. At present, two psychiatrists and a technical assistant work at headquarters; two psychiatrists have been attached as mental health advisers to the regional offices for Europe and the Eastern Mediterranean respectively, and a third regional adviser is about to be appointed in the regional office for the Americas (the organizational structure of which has been in existence since 1901 under the name of the Pan American Sanitary Bureau).

Apart from this permanent staff, the organization employs short-term consultants. Some of these visit those member countries that desire to have the collaboration of international experts; they render assistance by surveying the existing organization of services and by offering technical advice on future developments. Others collaborate directly with the officers in charge of the mental health program of the organization, either at headquarters or in the regional offices. In certain cases, the organization also provides specialists, at the request of member governments, on a long-term basis. These are usually experts with a special competence in a specific field of mental health practice, and their function is to work alongside their local colleagues and to prepare their national counterparts for independent continuation of the activity in question.

There is a division of labor in the sense that the foremost task of the headquarters unit is the development and formulation

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of what might be termed the WHO policy in mental health matters, while the regional offices are normally responsible for the organization of field activities. This is the reason why the headquarters unit enjoys the help of yet another category of expert: the members of the Expert Advisory Panel on Mental Health. This panel comprises, at present, 70 experts from 35 countries; the participants of the periodic expert committee sessions are drawn from its ranks. This does not mean that the regional offices do not make use of expert advisers; as a matter of fact, they do quite frequently. Nor does it mean that only the members of the expert panel can be invited to meetings; there are study group meetings that deal with special types of problems and in which outside experts often cooperate. It is true, however, that the expert committee meetings are the main instrument of the organization in respect to policy development, and great care is taken, therefore, to make these meetings (usually limited to seven to nine members) as representative as possible, particularly from the point of view of the geographical and cultural distribution of the participants.

EXPERT COMMITTEE ON MENTAL HEALTH

Between 1949 and 1959, the Expert Committee on Mental Health held eight meetings, and since the reports of these meetings reflect the development of WHO's work in the mental health field particularly well, a short resumé is given below:

(1) *First Expert Committee* (August 29–September 2, 1949) [1]

In this meeting the Expert Committee set itself the goal of outlining an international mental health program. The committee expressed its belief that "it will not be possible within the foreseeable future to provide throughout the world for all peoples therapeutic psychiatric facilities of the level already provided in the more developed countries" and it therefore put forward the opinion that "it is only by the preventive application of psychiatric knowledge that mental health problems can ultimately be solved." In connection with this, it stated that "the most important single long-term principle for the future work of WHO in the fostering of mental health is the encouragement of the incorporation into public health work of the responsibility of promoting the mental as well as the physical health of the community."

As a second principle the committee put forward "the desirability of concentrating especially on the therapeutic and preventive psychiatry of childhood." It gave a warning against "the automatic reproduction of methods and techniques evolved in other countries" instead of trying in each case "to reach methods of handling the problems appropriate to the local situation." With respect to the education of mental health workers, the committee recommended "the re-casting of undergraduate medical education to ensure that it gives to the undergraduate an understanding of normal psychological development and of the origin and nature of common psychological disorders equal to that which is already provided in the organic field." It emphasized "the importance of incorporating an understanding both of psychiatric nursing and of the psychological aspects of general nursing into the training of every general hospital nurse" and the equipment of public health nurses with sufficient knowledge to enable them "to contribute to preventive mental health work by the advice they give to parents on the handling

[1] *World Health Organization Technical Report Series*, 1950, No. 9.

of infants and children." The committee also emphasized the importance of adequate health education of the public and of well-planned and well-conducted research. Finally, it stressed the need to study such specific problems as alcoholism, drug addiction, exposure to venereal diseases, juvenile delinquency and others and made a number of suggestions as to ways of achieving this program, including reference to collaboration with other international governmental and non-governmental agencies.

(2) *Second Expert Committee* (September 11–16, 1950) [2]

In this meeting, the committee concentrated on the need to introduce mental hygiene into public health practice. It pointed out that psychiatry "developed as a personal service to the sick individual" and that "only recently . . . psychiatrists have attempted to contribute to preventive medicine." It felt that it is "incumbent on psychiatrists to recognize their responsibility to public health practice" and said that "the public health worker needs the support of the psychiatrist not only in handling those problems which are beyond his competence but also in integrating the principles of mental hygiene into his practice." From this point of view, the committee went into a detailed consideration of the mental health aspects that should be considered with respect to maternity services, the infant and the pre-school child, school health, the handicapped child, the management of communicable diseases, the care of the aged, health education of the public, and migration. It also referred to the need to develop health statistics with respect to mental disorders and to foster what in recent years has come to be called the "epidemiology" of psychiatric disorders. It paid attention to the mental health factor in the activities of public health administrations and recommended the provision of systematic mental hygiene training for public health workers. With respect to this latter point, it stated two general principles: (a) "Mental hygiene training should aim at giving the public health worker a broad understanding of human behavior and should not consist of a formal course in psychiatry," and (b) "Such material as is presented will be more effective if it is integrated into the various established courses in the curriculum rather than given as a separate course."

(3) *Third Expert Committee* (November 24–29, 1952) [3]

At its third meeting, the committee analyzed the requirements of psychiatric hospitals, paying special attention to the necessity of keeping psychiatric institutions in the closest possible contact with the surrounding community. It gave a warning against the common belief that the psychiatric problems of a community could be solved by the provision of more and more hospital beds. With respect to this question, it stated that "probably any community will ultimately find it necessary to provide at least one psychiatric bed per 1000 of the population," adding that "once this level has been reached, however, it must not be assumed that the next step in the development of psychiatric services is to increase the number of psychiatric beds. It is probably preferable that the moment the provision of beds reaches this level, those responsible for planning psychiatric services should devote at least as much attention to the development of extra-mural treatment facilities and other psychiatric

[2] *World Health Organization Technical Report Series*, 1951, No. 31.

[3] *World Health Organization Technical Report Series*, 1953, No. 73.

activities within the community side-by-side with any further increase in the provision of psychiatric beds. There is no doubt that in the past too much attention has been given to the mere provision of further psychiatric beds and too little to the development of a real community mental health service."

The committee then went into a detailed analysis of the steps which should be taken in the development of community mental health services. It stressed the importance of preventive and educational extra-mural activities and of the necessity of providing extra-mural treatment.

"Out-patient work," it said, "is the antenna of the community mental hospital and . . . from the clinical experience of this service may be derived the most reliable indicators of the direction in which the hospital should develop if it is to meet the needs of the community it serves." One organizational type that the committee recommended particularly was the "day hospital." It pointed out that "the day hospital may succeed in helping the recovery of various types of patients whom it was difficult to help until now," and described it as "a distinct and important addition to the means of treating psychiatric patients and one which every community mental hospital should consider establishing." With respect to the in-patient services of the community mental hospital, great stress was laid on the creation of a "therapeutic atmosphere." Among the elements necessary for this it mentioned: (a) the preservation of the patient's individuality; (b) the assumption that patients are trustworthy; (c) the assumption of the patients' capacity for a considerable degree of responsibility and initiative; and (d) an intense, planned, and purposeful activity.

With respect to treatment, the importance of social treatment was particularly stressed. The committee insisted on the formation of a true therapeutic team in which doctors, nurses, social workers, and others have an equally valid role. It expressed its belief that it is "undesirable to build new psychiatric hospitals for more than 1000 patients" and voiced the opinion that "the optimum capacity for a hospital probably lies between 250 and 400 beds." It expressed the view that a psychiatric hospital "should be situated in the immediate vicinity of the community it is to serve" and considered that if this condition were fulfilled, it might be preferable to the inclusion of psychiatric wards in general hospitals.

(4) *Fourth Expert Committee* (November 1–6, 1954) [4]

On this occasion, the committee considered the legislation affecting psychiatric treatment. After pointing out that the attitude of society towards the mental patient is changing, it criticized the legislation affecting the mentally ill that exists at present in many countries, outlined the essential requirements to be met by legislation, and paid special attention to the legislative aspects of the problem of the unwilling patient and of the organization of the psychiatric service. It discussed what kind of mental health act was needed and came to the conclusion that "a single mental health act covering both the mentally ill and the mentally sub-normal was the most useful form of legislation."

It said, furthermore: "Laws which set out in detail the kind of establishment to be set up or which lay down detailed provisions regarding the medical and nursing care of patients or the numbers of staff required are more likely to hinder than to assist the evolution of good psychiatric services. Such things are better left to regu-

[4] *World Health Organization Technical Report Series*, 1955, No. 98.

lation, and the law should merely prescribe who should make the regulations and who should ensure that they are carried out." In connection with this specific problem, the committee again insisted on the need to apply the principles set out in accordance with the type of social structure which prevails in a country.

"What is required," it said, "is to give these patients facilities for treatment and the possibility of guardianship and medical supervision in accordance with their medical needs and social inadequacy. . . . No one system can be applicable to several different countries, and even in one and the same country, the systems advocated by some will be repudiated by others. Any system which comes into conflict with legal or cultural conceptions is inapplicable. It would seem, therefore, that preference should be given above all to establishing laws strongly integrated into cultural traditions while at the same time leaving the way open for possible changes."

(5) *Fifth Expert Committee* (December 10–15, 1956) [5]

In its fifth meeting, the Expert Committee took up a theme that had been introduced in the first session: the gap which, particularly in "well-developed" countries, often exists between strong therapeutic facilities and weak preventive services. It pointed out that this gap "should not be allowed to open where mental health care is still in its beginnings." Referring to the conclusions made in the third committee report, it expressed the view that "the psychiatric hospital is often the only place where systematic mental health work can be undertaken and where possibilities for further education and training in the mental health field exist" and then went on to examine "the conditions which will enable the psychiatric hospital service to carry out preventive work together with its curative activities." In dealing with this subject, the committee studied the relationship between therapy and prevention and stated that "the development of mental hygiene is intimately linked to the advancement of psychiatric therapy not only because an effective early treatment of mental disorder can in itself be considered as preventive but even more because the progress of therapy helps . . . to create favorable conditions for positive prevention."

It examined in particular the significance of the "opening" of the psychiatric hospital for its preventive usefulness and indicated an "ideal structure of an integrated mental health service" with its possible variations. In this respect, it emphasized the desirability of providing as the "central structure of a mental health service," "a relatively small active treatment unit which could be provided with the necessary out-patient facilities and, in some parts, with mobile units." It compared this type of unit with the "long stay unit," to which it accorded a lower degree of priority. The committee referred extensively to the training of the psychiatric hospital team for preventive activities, emphasizing the value of team work and the need for retraining older personnel. It summed up by saying that "an adequately organized psychiatric hospital with its extensions into the social life of the community and firm links with the other branches of public health is the rational starting point and base camp for a truly efficient mental health service."

(6) *Sixth Expert Committee* (September 1–6, 1958) [6]

The sixth meeting of the Expert Committee was devoted to the special mental health

[5] *World Health Organization Technical Report Series*, 1957, No. 134.

[6] *World Health Organization Technical Report Series*, 1959, No. 171.

problems of aging and the aged. It set itself the task of examining first "the reinforcement of the mental health of the aged themselves" and secondly "the promotion of society's awareness of the needs and possibilities of its older members." In order to do this, the committee considered it "necessary to place the mental health problems of aging and the aged in their demographic, epidemiological, and medical setting." In this connection it paid particular attention to cultural and social differences with respect to the quantity and quality of the problems encountered. It studied socio-economic, psychological, psychopathological, and different types of physical factors and recommended measures from the point of view of social management, public health, and education. One of the main items considered was the organization of geriatric mental health services. It was stated that "the health problems of the aged can be solved only by a wide extension of facilities for care in the community." In particular it was pointed out that "an adequate community mental health service must have several lines of defense including comprehensive domiciliary provisions with home helps, social workers, health visitors, nurses and consultant psychiatrists, clubs with recreational facilities for the aged, sheltered workshops and residential accommodation of a warm, home-like character, as well as out-patient clinics, day hospitals and long- and short-stay annexes, and the mental hospital." Finally, the committee proposed a classification of mental disease in old age and commented in a detailed way on specific measures of treatment and rehabilitation and on the need for research on gerontology.

(7) *Seventh Expert Committee* (October 20–25, 1958) [7]

On this occasion, the Expert Committee re-examined the relations between psychiatric work and community life from a new angle. It pointed out that advances in psychiatric practice had led to the development of a more intense consideration of social factors in the causation as well as in the prevention and care of mental illness. It defined social psychiatry as referring "to the preventive and curative measures which are directed towards the fitting of the individual for a satisfactory and useful life in terms of his own social environment," and stated that "in order to achieve this goal the social psychiatrist attempts to provide opportunities for the mentally ill and for those in danger of becoming so for making contacts with society which are favorable to the maintenance or re-establishment of social adequacy." In this connection, the committee examined the attitudes of the community with a view toward fostering an increased cooperation between its members and the mental health personnel and formulated the problem in the following terms: "The psychiatrist is nowadays often able to place a person at the door through which he can set out into normal life, but this action will not have the desired effect if outside that door is only empty space. If society is to reap the full benefit of the advance of modern psychiatry, it must learn to collaborate in the prevention of mental disorder and in the therapy and rehabilitation of the mentally ill."

With this in mind, the committee examined in detail the different types of community attitudes and analyzed, in particular, the current concepts of mental illness and its origin, the prevailing notions of normality and abnormality and the atti-

[7] *World Health Organization Technical Report Series*, 1959, No. 177.

tudes towards certain symptoms, the prognosis and the treatment of mental disorder. It also studied the reaction of the community to different clinical types such as psychotics, neurotics, psychopaths, the mentally subnormal, abnormal children, and abnormal persons of advanced age. Special attention was paid to the influence of different community structures and of certain community institutions, such as organized religion, law, and educational systems. The influence of age and education and of personality factors was examined, and the role of specific groups, such as patients' families, community leaders, employers, health personnel and the patients themselves, was reviewed. The committee then went into a detailed study of community attitudes towards psychiatric practices and psychiatric personnel. Here again, care was taken to contemplate different social and cultural situations as well as the existing types of psychiatric treatment. In its recommendations, the Committee advised an extension of active treatment and community care and referred in a detailed way to the content and methods of information and education and to the community groups which should be taken into account from this point of view. Reference was made in this respect to psychiatrists, psychologists, social scientists, general physicians, community health workers, different types of community leaders, and the families of the patients. The committee also made a series of recommendations on research, particularly with regard to systematic attitude research.

(8) *Eighth Expert Committee* (June 8–13, 1959) [8]

At its first meeting, the Expert Committee had already stated that "an understanding of the true incidence of psychological disorders" can only be obtained "by sampling studies." At its third meeting, the Committee returned to this topic and recommended that it would be necessary "to carry out . . . surveys of sample communities in order to arrive at a working estimate of psychiatric morbidity." It also mentioned that "apart from their practical value, comparative studies of the prevalence of psychiatric morbidity which compare that found in different communities, different social groups, and different cultural patterns are of very great theoretical importance, because they may well throw light on important etiological factors and thereby open the way to more effective prevention." In its eighth meeting, the committee concentrated on the task of studying the "epidemiology of mental disorders," i.e. "the study of their distribution and behavior under differing conditions of life in human communities." The committee lamented the fact that "no satisfactory solution has yet been reached" with respect to the provision of "a generally accepted system of statistical classification which allows data obtained by various investigators to be confidently compared." It commented upon the difficulties inherent in the International Statistical Classification of Diseases at present in use and pointed out the conditions which a satisfactory classification would have to fulfill. In this respect, it stressed that a future classification would have to observe "neutrality in the controversies between various schools of thought;" that "it must be a servant of international communication rather than its master," and that it should not try "to take the place of regional or local classifications which will often . . . advance knowledge." Particular attention was paid to

[8] *World Health Organization Technical Report Series*, 1960, No. 185.

epidemiological method, which was mentioned with regard to operational and clinical studies. The conduct of field surveys are covered in considerable detail. There were recommendations particularly with respect to sampling and sampling methods, case-finding, standardization of psychiatric diagnoses, selection and definition of clinical terms, methods for covering data on individuals, screening devices, and the use of standard clinical case material. Reference was made to the possibility of using controlled experiments or of taking advantage of "experiments of opportunity." The committee examined in detail the problems of staffing for epidemiological work in psychiatry and made recommendations for training. There were, finally, many suggestions for research, both on methods and concepts and on operational and clinical problems.[9]

ADDITIONAL EXPERT COMMITTEES

It would not be appropriate to refer in this paper only to the expert committees which dealt with problems of general mental health interest. There were also others which examined more specific problems, often jointly with the expert committees of other units of the organization, or with other agencies of the United Nations family. The work done by these committees will be reviewed below.

(1) *Expert Committee on Psychiatric Nursing* (August 29–September 3, 1955) [10]

This expert committee, organized jointly by the nursing and the mental health sections of the organization, tried to find common elements and general principles that could be applied to the organization of nursing care in different areas. The committee recognized that "in every country psychiatric nursing practice is directly related to cultural attitudes toward the mentally ill and to the development of psychiatry and of nursing as a profession" and that therefore the methods will vary and fulfill the essential needs in succeeding stages according to the total facilities available. It pointed out, however, that the role of the psychiatric nurse was gradually changing in so far as a shift was taking place from "an 'inter-personal' concept of patient behavior to an 'intra-personal one' " and "from a custodial role to a therapeutic one." Accordingly, "the education of the nurse moves from the descriptive, didactic type of program to one which will provide her with more therapeutic skills in nursing her patients." "Understanding of personality growth and development, theories of human behavior, concepts of anxiety, sociological aspects of psychiatric care and group methods . . . begin to form an integral part of the educational and experiential background of the nurse."

The committee first examined in a detailed way the role of the psychiatric nurse with regard to the factors determining it and the different steps in its development within the mental hospital. It reviewed the essential nature of psychiatric nursing referring to patient care, supervision, community health activities, extra-mural activities, community care before and after hospitalization, and the special problems of general hospital and public health nurses. It then referred to the needs with respect to the education of psychiatric nursing personnel, paying special attention to methodology and recommending a basic curriculum. The committee finally made

[9] It may be worth while mentioning that the Expert Committee will have two more meetings in 1960; the first will examine the undergraduate teaching of psychiatry and mental health promotion; the subject of the second will be program development in the mental health field.

[10] *World Health Organization Technical Report Series*, 1956, No. 105.

recommendations with respect to research needs, particularly with regard to research in clinical nursing, nursing education, nursing administration, and the preventive aspects of psychiatric nursing.

(2) *First Meeting of the Alcohol Sub-Committee* (December 11–16, 1950) [11]

This sub-committee of the Expert Committee on Mental Health approached alcoholism as a disease and as a social problem. It expressed the view that the public health services could and should make extensive contributions, but that legal or social measures related to the distribution and use of alcohol were also of considerable value. It pointed out that alcoholism is likely to pass through a series of stages which it described as symptomatic drinking, addictive drinking, and alcoholic deterioration. With respect to the incidence of alcoholism, it recommended the use of the so-called "Jellinek formula" which is said to allow the determination of the size of the alcohol problem in terms of the incidence of liver cirrhosis and the mortality therefrom. As to treatment, the committee referred to facilities and means, and in the latter respect, expressed its belief in the efficacy of pharmacological treatment by Disulfiram. Finally, the committee made some remarks on the education and training of health workers with regard to alcoholism and the value of cooperation with such voluntary organizations as "Alcoholics Anonymous."

(3) *Second Meeting of the Alcohol Sub-Committee* (October 15–20, 1951) [12]

In its second meeting, the Alcohol Sub-Committee concentrated more on practical and specific aspects of the problem of alcoholism. Without prejudice to the preventive aspects of a program, the committee felt that "progress in the various phases of the problem of alcoholism is most feasible only after the large number of alcoholics throughout the world has been considerably diminished through a large scale rehabilitation effort." Referring again to the different stages of alcoholism, the committee examined the existing treatment facilities and went into a detailed discussion of the treatment by Disulfiram. The committee further made some remarks about the statistics and the classification of alcoholism. An annex referring to statistics in the surveying of alcoholism and alcohol consumption was added to the report.

(4) *Expert Committee on Alcohol and Alcoholism* (September 27–October 2, 1954) [13]

This expert committee was organized jointly by the mental health section and the section on addiction-producing drugs which had convened an Expert Committee on Alcohol in 1953. This 1953 committee had reviewed the alcoholism problem from a more pharmacological point of view.[14] In the expert committee under review, the psychiatric and the pharmacological approaches were taken into account side-by-side in order to facilitate "a direct exchange of experience among pharmacologists, physiologists, and psychiatrists as well as their agreement on the interpretation of some basic conceptions of alcoholism." One of the main topics of this session was the combined problem of physical and psycholog-

[11] *World Health Organization Technical Report Series*, 1951, No. 42.

[12] *World Health Organization Technical Report Series*, 1952, No. 48.

[13] *World Health Organization Technical Report Series*, 1955, No. 94.

[14] *World Health Organization Technical Report Series*, 1954, No. 84.

ical dependence and the occurrence of withdrawal symptoms. The committee described the "craving" for alcohol and the signs appearing after a sudden cessation or reduction of alcohol intake. It also pointed out the prognostic importance of alcoholic amnesias (so-called "black-outs"). The position of alcoholism in relation to drug addiction was examined, and the opinion was expressed that alcohol must be placed "in a category of its own, intermediate between addiction-producing and habit-forming drugs." The disorders induced by alcohol were finally classified with special consideration of the public health action called for by each of the categories distinguished.

(5) *Expert Committee on the Mentally Subnormal Child* (February 16–21, 1953) [15]

This expert committee was organized by the World Health Organization with the participation of the United Nations, ILO, and UNESCO. Its purpose was to give consideration "to the special problems presented by persons suffering from milder forms of mental subnormality or social incompetence." It was pointed out that children of this type often lack the assistance that would enable them to make full use of their limited abilities and potentialities. "In school they are very often educationally more backward than they need be, and in both adolescence and adulthood many of them present serious problems that would not have arisen had they been properly cared for in childhood."

It was proposed to divide mental subnormality into mental retardation and mental defect and to differentiate in both categories between mild, moderate, and severe forms. The term "mental retardation" was proposed for "those whose educational and social performance is markedly lower than would be expected of what is known of their intellectual abilities," while the term "mental defect" was reserved for those whose "mental capacities themselves are diminished as a result of pathological causes." It was indicated that much research was required in order to determine the prevalence, the etiology, and the methods of assistance with regard to the different types. With respect to prevention, attention was called to the relation between emotional deprivation and mental subnormality. The committee reviewed in detail the services necessary for the treatment and education of mentally subnormal persons in infancy and early childhood, during school age, and in adolescence and early adulthood. It pointed out the need for special educational facilities and appropriate vocational guidance and vocational training. Reference was made to the training of personnel for the treatment and education of subnormal children. It was pointed out that a proper handling of these problems is only possible if the intelligent cooperation of the parents and the general public is assured. The need for special legislation was stressed, and in this connection it was stated that the main function of legislation relating to the subnormal must be protective, that over-protection should be avoided, that the required legislation should, as far as possible, be made within the framework of the general legislation referring to the rights and needs of children, and that machinery should be set up to provide for special contingencies such as guardianship, institutional care, procedures of certification or commitment, etc. The committee finally recommended that in the development of programs for the assistance of mentally subnormal children, care should

[15] *World Health Organization Technical Report Series*, 1954, No. 75.

be taken to secure appropriate coordination of services, not only in the planning and execution of programs, but also in relation to the individual cases.

STUDY GROUPS

It has already been mentioned that in order to discuss problems of a very specialized nature, so-called "study groups" can be convened. Some of these were organized by the mental health unit alone, while others were arranged in cooperation with other units. A short resumé of the work done by these study groups is given below.

(1) *Study Group on the Psychobiological Development of the Child* (January 26–30, 1953; January 7–13, 1954; February 17–23, 1955; September 20–26, 1956) [16]

In its first session the Expert Committee on Mental Health recommended that WHO should foster "research into the biological, psychological, and cultural determinants of personality structure," and also "actively sponsor psychological studies of the normal pattern of emotional and intellectual development in infants and children . . . since for mental health work a knowledge of the normal pattern of emotional and intellectual development is as important as is a knowledge of normal physical development to a pediatrician." Accordingly, a group was convened consisting of psychologists, psychiatrists, psychoanalysts, electrophysiologists, biologists, educationalists, cultural anthropologists, and animal psychologists, who examined child development with a view to synthesizing their different viewpoints.

In the first meeting, the knowledge (or lack of it) of the growth and maturation of the human nervous system, and the electroencephalographic changes during childhood were described; Piaget's and Wallon's systems for describing the stages of cognitive and of motor development were outlined; current psychoanalytic theory as to the stages through which the child passes was briefly reviewed; the effects of different cultures on the rate and manner of emotional and intellectual development were described; and the elements of the comparative studies of animal behavior were outlined, with emphasis on the innate releaser mechanism and imprinting.

Presentations were made from each of the standpoints of different specialists and were discussed by the whole group, partly with the object of revealing the most important gaps in knowledge where further research would be important, and partly with the object of stimulating inter-disciplinary interest and coordination. It was stated that the physical or physiological growth process could be visualized as a series of waves of activity, affecting different parts of the body at different times; that one should not consider sharply-defined critical points in that growth period, but that probably there were periods of greater or less susceptibility to outside influences. It was shown that the relation between physiological and psychological developments required further study, as did the differential development as between the sexes. A description was given of the pattern of integration of the motor function by the central nervous system studied through the behavior of anencephalics. Stages of mental development were examined and illustrated by descriptions of

[16] No reports on the sessions of this study group have been published by the World Health Organization. However, a condensed (English) version of the verbatim record of the first three meetings has appeared in London (Tavistock Publications, Ltd.) and New York (Basic Books, Inc.). A fourth volume containing the record of the last meeting is in print, and the publication of French and Russian versions is contemplated.

tests for the existence of "mental structures" as compared with tests of isolated pieces of behavior. It was pointed out that the study of structured wholes was insufficient if not completed by research in differential psychology. Behavior was discussed with particular reference to "instinctive" behavior or innate response to key stimuli, as compared with behavior resulting from conditioning and from learned responses. EEG records were related to certain aspects of children's personalities, particularly ductility, versatility, and stability, and an attempt was made to relate developmental changes in characteristic EEG activity to the stages of mental development previously described. Instinct theory was reviewed with particular reference to the concept of psychiatric illness as resulting from a disorganization of instinctual life, and of regression to the stages of instinctive response in infancy as affecting the behavior patterns in adult life. Finally, it was shown that what are considered as normal stages of development in one culture are not necessarily so in another.

In the second meeting, electromechanical models simulating aspects of animal learning and of the possession of "purpose" were demonstrated and discussed; experiments on what happens to humans when they are cut off from the majority of stimuli were described; some ways were demonstrated in which emotional crises can be produced in animals, both in adults and young animals; evidence was presented on how learning in children through identification and superego development occurs in different cultures. A presentation by a neurophysiologist postulated six main modes by which psychobiological development could occur, some of which were illustrated by thermionic models designed to show human behavior reduced to simple terms. Development through "reflexive" action was demonstrated by a model showing purposive behavior which was shown to be not dependent on an elaborate nervous system. Another model, designed to show adaptation by imprinting, by instinct, and by association, appeared to have the property of allowing for a very specific response to be built up and later allowing for a variety of response, without any anatomical transformation (as in growing children).

It was pointed out that for the demonstration of development through learning by association or by conditioned reflexes a far more elaborate model was required. A description was given of toposcopic methods of observing how the human brain deals with information received, and was illustrated by case material. Factors in the normal development of behavior as studied by human and animal experiments in a psychological laboratory were then described. One series of experiments concerned the role of early learning or early experience in emotional and problem-solving behavior. Sensory or perceptual deprivation in the human adult was shown experimentally to result in loss of concentration and sometimes in hallucination. Other lines of research described concerned individual differences in reaction to stress and the reinforcement theory of learning. Since studies of chronic emotional disorders brought on by the stresses of conditioning in animals have contributed to an understanding of the functional significance of human emotions, a number of experiments carried out for this purpose were described, including some on the differences in reactions to stressful training between young animals left with and without their mothers during the experiments. Details were given of a comparative study of certain aspects of psychological development in different cultures. There was further discussion on behavior patterns in infants, on the possi-

bilities of measuring the learning process in man and its disorders by electrophysiological methods, and on the psychological process of registering facts and "storing" experience.

In the third meeting, the number of subjects discussed diminished although the range of the discussion was as wide as ever. The ways were described in which different cultures bring their children to assume a social role appropriate to their sex and the relation of this to adult sex differences in behavior and sex differences in emotional attitudes of American twelve-year-olds, as revealed in the models they made when asked to construct an exciting but imaginary scene with toys, were presented. The stages in the psychosocial development of the child were presented and discussed, with particular emphasis on how the values of his culture are transmitted to the growing child. Observations made in intensive clinical work, in a longitudinal study and in anthropological studies were used as a basis for the discussion of the development of ego-identity. Much discussion during this meeting was devoted to an attempt to translate the stages described in the development of personality by psychologists and psychoanalysts into neurophysiological terms, with reference also to cybernetic parallels.

In the fourth meeting, a somewhat different procedure was followed. This time one member of the group produced a paper for circulation, and the other members wrote comments on it. These comments were, in turn, precirculated. A discussion then took place, and afterwards, a final statement was circulated by the writer of the original paper. The main concern of this meeting was to find a level at which synthesis of the viewpoints and content of the various disciplines represented by the group could be made. This was perhaps the most interesting, but certainly the most difficult, task undertaken. The concerted attempt at a synthesis led to a search for a language in which more than one branch of knowledge may be described, the language of information theory, general systems theory, and probabilistic logic. As a result, it became evident that in many cases different terminology had been used for the same ideas by the various workers, and that there was much greater agreement on the general problems of development than had originally been supposed. As a counterpoint, there was renewed discussion on the stages in a child's development, and a clearer understanding was reached with respect to interaction of the different factors—biological, psychological, and cultural—involved in it, of the way characteristic stages follow one another, and of the mechanisms at play.

(2) *Study Group on Juvenile Epilepsy* (October 6–12, 1955) [17]

This meeting was convened "with the aim of obtaining as comprehensive a picture as possible of the problem of epilepsy and how to handle it, and to show this picture as widely as possible in various countries with the object of setting in motion the development of services." The group considered the prevalence, pathophysiology, and etiology of juvenile epilepsy. It referred to the role of the centrencephalic and temporal lobe systems in the pathophysiology of epileptic fits and commented upon the EEG patterns and their relationships to different forms of attacks. With respect to etiology, reference was made to hereditary factors, and the acquired factors were analyzed in detail. Much attention was paid to the psychological phenomena associated with juvenile epilepsy, such as secondary disturb-

[17] *World Health Organization Technical Report Series*, 1957, No. 130.

ances of intelligence and behavior, primary and secondary neurotic complications, etc. Recommendations were made on the organization of medical and social guidance for the epileptic child and the problems of case-finding, pharmacological, surgical and psychological treatment, social handling, and educational and vocational practices were discussed. Finally, reference was made to the public health aspects of juvenile epilepsy, and measures for primary and secondary prevention were mentioned.

(3) *Study Group on the Treatment and Care of Drug Addicts* (November 19–24, 1956) [18]

The task of this study group, which was organized jointly by the mental health section and the section on addiction-producing drugs, was to examine the scientific knowledge and clinical experience on the treatment and care of drug addicts with a view to determining the principles which might be applied to the management of addicts with different etiology and coming from different cultural surroundings. The study group accepted the public health concept that "an addict is a person who habitually and compulsively uses any narcotic drug so as to endanger his own or others' health, safety, or welfare." Of the different drugs used and abused, only the opium alkaloids, the substances with morphine-like characteristics, and the cannabis substances were considered. The study group agreed that it is "not possible to describe the addict as a well-defined type," and with respect to the classification of addicts it decided to base it on the amenability of addicts to treatment. It differentiated between a group of persons "who are exposed to some more or less accidental circumstances, such as exhaustion, hunger and poverty," a group of persons who become addicted as "the result of some episode of an illness physical or psychological in origin," and a group of addicts "composed of those who suffer from a basically pathological character structure." With respect to the treatment to be carried out, consideration was given to the (legal and administrative) circumstances of treatment and to the general principles of treatment. With regard to the latter, the group said that "it cannot be too strongly emphasized that the first principle of the treatment of drug addicts is that they should be looked upon as patients, that is to say, treated medically and not punitively."

It was also pointed out that "treatment must be based upon a study of the individual personality" and should therefore be of a fundamentally psychotherapeutic nature. The study group divided the treatment period into a preparatory phase, a withdrawal phase, and a phase of continued treatment, "all of which should be part of a continuing process which may have to extend over several years." The methods of gradual and abrupt withdrawal were described. With reference to the withdrawal of opiates or morphine-like substances, the Methadone substitution technique was recommended as being most effective, simple, and easy to carry out. The group noted a number of subjects for further study and in an annex furnished some background information on the etiology of addiction, the circumstances of treatment, and the treatment programs in use at present.

(4) *Study Group on Schizophrenia* (September 9–14, 1957) [19]

Immediately after the Second International Congress on Psychiatry (Zurich, September 1–7, 1957), the central subject of which

[18] *World Health Organization Technical Report Series*, 1957, No. 131.

[19] No report of this study group was published by the World Health Organization. A report was printed, however, in the *American Journal of Psychiatry*, 115(1959), 865–72.

was schizophrenia, 12 distinguished investigators were invited to review the problems of that disease, which, in many countries, accounts for more than half the number of hospitalized psychiatric patients. The group pointed out that "the diagnosis of schizophrenia has to be made on clinical evidence" and that "it cannot . . . depend on the course of the illness." The prominent clinical criteria of the illness were listed as: (a) an unmistakable change of personality; (b) social withdrawal with preference for private modes of thought and behavior (autism); (c) a disturbance of thinking; (d) emotional disturbances; (e) disturbances of perception; and (f) anomalies of behavior.

With respect to the etiology of schizophrenia, the group expressed the view that "the opinion which at present prevails . . . is that this disorder is in all cases of multifactorial origin, although the relative importance of different factors may vary from patient to patient." With regard to treatment, the group stated that "nearly every schizophrenic will respond favorably to at least some degree" and that the three types of treatment available, "somatic, psychological, and environmental, are complementary." The group pointed out that "no specific preventive measures are available," but that "all factors which permit good mental health may be assumed to be of use in preventing some of the manifestations." It also stressed that by appropriate measures a worsening of the condition or a chronic course can often be prevented ("secondary prevention"). The group finally made recommendations with respect to training, research, and public education.

(5) *Study Group on the Mental Health Aspects of the Peaceful Uses of Atomic Energy* (October 21–26, 1957) [20]

In its activities concerning the risks to health involved in the exploitation of nuclear energy, the World Health Organization considered in the first place the physical aspects. Since, however, "the opening of the Atomic Age may also be accompanied by pathogenic influences in the sphere of mental health," a study group was convened in order to examine and analyze these influences. The group started by reviewing the question of possible brain damage from radiation and came to the conclusion that "with the low dosages of radiation to be encountered in the peaceful uses of atomic energy, the organic brain effects . . . are of minor or no importance." It then tried to determine "the degree to which the development of atomic energy may affect mental health through the action of social and economic factors" and expressed the view that "the peaceful use of atomic energy has enormous potential for both helpful and harmful effects," and that "the question as to which effects will predominate hinges on the attention given to human factors in planning and in development." The group then sifted the evidence on unhealthy emotional responses immediately provoked by the advent of atomic energy, referring in this connection to the general public, the press, the authorities, the personnel of atomic establishments, and the radiologists and atomic scientists. It then analyzed this evidence, pointed out the anxiety-producing circumstances and qualities of atomic energy and their relationship to certain childhood experiences, and commented on the psychological interaction between scientists, authorities, and the general public. Finally, the study group outlined the mental health tasks which result from the problems encountered, suggesting remedial, educational and research measures with respect to brain damage, socio-economic risks, and specific

[20] *World Health Organization Technical Report Series*, 1958, No. 151.

emotional reactions. It also recommended the formation of interdisciplinary teams whose task it would be to contribute to the education of the community on different organizational levels.

(6) *Study Group on Ataractic and Hallucinogenic Drugs in Psychiatry* (November 4–9, 1957) [21]

The growth of interest in the action of ataractic and hallucinogenic drugs on mental function in man motivated the convening of this study group, which tried to limit its discussion to subjects not previously covered in other conferences and symposia and to emphasize those aspects in which the facilities of the World Health Organization could play their part. The study group started by examining the origins of present ignorance with respect to tranquillizers and hallucinogenic (psychosomimetic) agents and referred in this connection to the subjective nature of drug effects in man, the uneven progress of the behavioral sciences, and the equally noticeable lag in the development of the basic neurological sciences. It tried to establish psychophysiological correlates and to interpret them in the light of a theory of the psychoses; the hypothalamus, the reticular system, and the limbic system were particularly referred to, and the influence of drugs upon the metabolic background of the psychoses was examined. The problems of classification of drugs were studied, and a provisional classification was proposed. Six major groups were distinguished: (a) the major tranquillizers or neuroleptics; (b) the minor tranquillizers; (c) the hypnosedatives and tranquillosedatives; (d) the anti-acetylcholine drugs with marked psychotropic effects; (e) the stimulant (psychoanaleptic or psychotonic) drugs; and (f) the hallucinogenic or psychosomimetic drugs. An effort was made to relate the drug-induced mental changes to psychoanalytic theory, and the implications of those considerations for psychotherapy were discussed. Although it was not within the terms of reference of the study group to weigh the relative merits of the various drugs in the management and treatment of the psychoses, some remarks were made on the effect of modern drug treatment on the hospital milieu and the future functioning of the mental hospital. Consideration was given to differences in the effects of and the needs for "psychotropic" drugs in different cultures. Finally, there was some discussion on specific research problems, and the uses and abuses of the new drugs were viewed from the public health point of view with regard to hospitalized and not hospitalized patients.

(7) *Study Group on the Mental Health Problems of Automation* (November 10–15, 1958) [22]

The mental health impact of socio-economic changes, which had already been touched upon by the Study Group on the Mental Health Aspects of the Peaceful Uses of Atomic Energy, was studied in a detailed and specific way by the Study Group on the Mental Health Problems of Automation. The group started by pointing out the similitudes and the differences between the traditional type of industrialization and automation and then went into a detailed consideration of the mental health effects of the latter, particularly of "control automation" and "computer automation." It reviewed the consequences of individual strain through work in automated plants, first from the point of view of the hopes and fears that automation is inspiring in

[21] *World Health Organization Technical Report Series*, 1958, No. 152.

[22] *World Health Organization Technical Report Series*, 1959, No. 183.

many people, and then with regard to the physiological and psychological repercussions of work in automated undertakings. With respect to the latter, special attention was given to the effects of a reduction of manual work, an increase in perceptual activity, a more abstract nature of the individual's relations with the machine, and an increased responsibility of the machine operator. With regard to the mental health problems connected with social change caused by the introduction of automation, the group considered the influences which may be derived from changes in the location of industries, a possible increase of shift work, a greater amount of leisure time, and changes in occupational structure and mobility, with special reference to the situation of middle-aged and older workers. The mental health tasks ensuing from the introduction of automation were analyzed with respect to the work place, the working individual, and the social environment. In this connection the group emphasized that automation should not be considered one-sidedly as a source of new types of strain but also as a source of possible improvements in mental health. Finally, the need for further research was underlined, and a list of urgent research topics was given.

OTHER EXPERT MEETINGS

Apart from the meetings of expert committees and study groups summarized above, the mental health unit of the World Health Organization collaborated in a number of expert meetings which were jointly organized with other agencies of the United Nations family and certain intergovernmental and non-governmental organizations.

Thus, the World Health Organization and UNESCO convened an "Expert Meeting on Mental Hygiene in the Nursery School," [23] which was held in Paris from September 17–22, 1951. The proceedings of this meeting were used as one of the preparatory reports for the UNESCO European Conference on Education and the Mental Health of Children, which met in Paris from November 27 to December 7, 1952. After having reviewed the development of the nursery school and its function in the community, the experts examined the role of the mother and of the nursery-school teacher in the light of the child's needs and made recommendations with respect to the recruitment and training of nursery-school teachers. Special attention was given to the functions of the headmistress in nursery schools and to the problems of supervision by school inspectors. The meeting also referred to the shaping of public opinion and said that "the nursery can probably make a more far-reaching impression upon public opinion than can any mass public information campaign."

The United Nations and the World Health Organization convened a "Meeting of Experts on the Mental Health Aspects of Adoption" [24] which met in New York from September 13–20, 1952. The meeting concerned itself with adoption procedures and the principles upon which they are based, with particular reference to the way in which they have developed within the structure of western society. It called attention to the "principles of mental health which are fundamental to good adoption practices" and stated that they "relate basically to the safeguarding of normal growth and development in the child and in particular to the adequate growth of a capacity for harmonious relationships." In this connection, the group

[23] UNESCO, *Problems in Education Series*, No. 9.
[24] *World Health Organization Technical Report Series*, 1953, No. 70.

expressed the opinion that "the capacity of the mother and father for parental feeling towards the child" is of particular significance for the growing person's development of positive social responses. The meeting analyzed the needs of the adopted child, made recommendations about adoption procedures, considered the problems of the natural mother and of the adopting parents, and commented upon the selection and the training of the persons engaged in assisting with adoption procedures. Summing up, the meeting pointed out that "it is no amateur matter to decide which parents and home will fit each child" and that, therefore, "no child should be placed haphazardly with any adopting parents."

The Commission for Technical Co-operation in Africa South of the Sahara, the World Federation for Mental Health, and the World Health Organization convened a "Meeting of Specialists on Mental Health" in Bukavu, Belgian Congo, from March 10–18, 1958. This "fact-finding" meeting was preparatory to the mental health seminar which was organized subsequently in Brazzaville, French Equatorial Africa (see next section). It concentrated first on making an inventory of the present position of mental health work in Africa, examining the historical background, and surveying the prevalence of mental ill-health, the existing treatment and prevention facilities, the staff situation, and the training facilities in the various African countries and territories. Then it discussed specific problems, such as the similarities and differences in basic psychology with regard to social and cultural patterns in the various areas and the effects of accelerated social and cultural change on the mental health of African populations. It finally examined the question of which problems call for research and what should be done with respect to future activities in the field of mental health.[25]

The Milbank Memorial Fund, the World Federation for Mental Health, the British Medical Research Council, and the World Health Organization convened a "Joint Technical Meeting on Epidemiological Methods in Mental Health," which was held in London from September 15–22, 1958. Approximately 20 specialists in psychiatry, public health, and epidemiology discussed a document on epidemiological method in psychiatry, which in 1957 and 1958 had been prepared by a WHO consultant, Dr. Donald Reid of London, with the collaboration of other WHO consultants and staff members, and heard reports on current research work in the field of the epidemiology of mental disorder. No report of this meeting was published, but the results of its discussions were incorporated into Dr. Reid's document, which was used as a working paper for the eighth session of the Expert Committee on Mental Health and has since been published [26] in the WHO series *Public Health Papers.*

MEETINGS ORGANIZED BY OR ON BEHALF OF WHO REGIONAL OFFICES

As was pointed out in the general introduction to this article, the regional offices are normally responsible for the organization of field activities. This includes the organization of seminars, the main purpose of which is to contribute to the training of mental health workers. The Regional Office for Europe, which was the first to appoint a regional adviser in mental health, plans and executes these seminars independently, while in the other regions, the technical responsibility for these meetings

[25] A report was prepared but has not yet appeared.

[26] World Health Organization, *Public Health Papers,* No. 2.

has so far been entrusted to the mental health unit at headquarters. The Regional Office for Europe has furthermore convened a number of symposia of an advisory nature whose task it was to collaborate with the regional staff in the clarification of problems of specific interest to the European region.

(1) SEMINARS

Regional Office for Africa

A seminar was convened in November–December, 1958, in Brazzaville, French Equatorial Africa. Its subject was "the education and training of mental health personnel in Africa south of the Sahara." The seminar was co-sponsored by the Committee for Technical Cooperation in Africa South of the Sahara. A report containing the proceedings and recommendations, as well as the working papers written in connection with this seminar, was produced but was not generally distributed.

Regional Office for the Americas

A seminar on alcoholism was organized in May, 1953, in Buenos Aires, Argentina. It was attended by specialists from Argentina, Chile, Paraguay, and Uraguay. No report was published.

A seminar on mental health was convened in Montevideo, Uruguay, in July, 1955. It was attended by specialists from Argentina, Brazil, Chile, Ecuador, Paraguay, Peru, Uruguay, and Venezuela and covered a wide range of topics, with particular emphasis on the prevention and treatment of mental disorders, the mental health problems of children, the training of mental health workers, and the mental health education of the public. No report was published, but a short resumé of the proceedings of the seminar was given in the *Chronicle* of the World Health Organization.[27]

Regional Office for the Eastern Mediterranean

A seminar on mental health was convened in November–December, 1953, in Beirut, Lebanon. The participants came from a wide range of Eastern Mediterranean countries. A report was produced but was not generally distributed.

Regional Office for the Western Pacific

A seminar on mental health in childhood was convened in August, 1953, in Sydney, Australia. Specialists from both Western Pacific and Southeast Asian countries attended. A report of the proceedings was produced but has not been generally distributed.

A seminar on mental health and family life was convened in Baguio, Philippines, in December, 1958. It was co-sponsored by the Philippine government, the World Federation for Mental Health, and the Asia Foundation. A report of this meeting has been prepared, but has not yet been published.

Regional Office for Europe[28]

A seminar and lecture course on alcoholism was convened in October–November,

[27] *WHO Chronicle*, 9(1955), 342.

[28] See also:

Buckle, D. F., "WHO Mental Health Program in Europe," *Journal of the American Medical Women's Association*, 13(1958), 454.

Buckle, D. F., "Das Mental-Health Programm der Weltgesundheitsorganisation in Europa, *Praxis der Kinderpsychologie und Kinderpsychiatrie*, 5(1956), 178.

Buckle, D. F., "Das Mental-Health Programm der Weltgesundheitsorganisation in Europa, *Zeitschrift für psycho-somatische Medizin*, 3(1956–57), 59.

1951, in Copenhagen. A report of this meeting was produced but has not been generally distributed.

A seminar on child psychiatry and child guidance work was convened in Lillehammer, Norway, in April–May, 1952. A report of this meeting was produced but was not generally distributed.

A seminar on the mental health aspects of public health practice was convened in Amsterdam, Netherlands, in July, 1953. A report was produced but was not generally distributed.

A seminar on the prevention and treatment of alcoholism was convened in Noordwijk, Netherlands, in March–April, 1954. A volume containing selected lectures presented at this seminar was produced but not generally distributed.[29]

A seminar on mental health through public health practice was convened in Monte Carlo, Monaco, in April, 1955. No report of this meeting was published, but a summary account of it appeared in the *Chronicle* of the World Health Organization.[30]

A seminar on child guidance was convened in Lausanne, Switzerland, in September, 1956. No report was published, but the material presented during this seminar was used in the production of a monograph.[31]

A seminar on the mental health of the subnormal child was convened in Oslo, Norway, in April–May, 1957. A report was produced but was not generally distributed.

A seminar on the nurse in the psychiatric team was convened in Noordwijk, Netherlands, in November, 1957. A report of this meeting was produced but not generally distributed.

A seminar on the psychiatric treatment of criminals and delinquents was convened in Copenhagen, Denmark, in April–May, 1958. A report was prepared but was not generally distributed.

A seminar on the mental health of the subnormal child was convened in Milan, Italy, in May, 1959. A report is in preparation.

A seminar on mental hygiene practice was convened in Helsinki, Finland, in June–July, 1959. A report is in preparation.[32]

(2) *Meetings of Symposia of the European Regional Office*

A symposium (advisory group) on the care of children in hospitals was convened in Stockholm, Sweden, in September, 1954. A report on this meeting was published in the *Bulletin of the World Health Organization.*[33]

A symposium on mental health problems of displaced persons was convened in Geneva, Switzerland, in August, 1955. The task of this group was to study a report on a 1954 pilot study on the mental health of children living in refugee camps in Austria.

A symposium on human relations and mental health in industrial units was convened jointly with the International Labor

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[29] World Health Organization, "European Seminar on the Prevention and Treatment of Alcoholism," selected lectures reprinted from the *Quarterly Journal of Studies on Alcohol,* 15(1954), and 16 (1955).

[30] *WHO Chronicle,* 9(1955), 247.

[31] Buckle, D. and S. Lebovici, "Child Guidance Centers," *World Health Organization: Monograph Series,* 1958, No. 30.

[32] Furthermore, a seminar on the medico-psychological and social examination of offenders was held in Brussels, Belgium, in December, 1951. This meeting was organized by the Technical Assistance Administration and the Department of Social Affairs of the United Nations Secretariat, with the cooperation of the World Health Organization. See *International Review of Criminal Policy,* (New York: United Nations, 1953).

[33] *Bulletin of the World Health Organization,* 12 (1955), 427.

Office in December, 1956, in Geneva. A report was produced but not generally distributed.

A symposium on preventive mental health work with children was held in Copenhagen, Denmark, in September–October, 1958. A provisional report was produced but was not generally distributed.[34]

PUBLICATIONS SPONSORED BY THE MENTAL HEALTH UNIT AT HEADQUARTERS

Partly in connection with meetings organized at headquarters, and partly with the purpose of advancing specialized knowledge in the mental health field, the mental health unit at headquarters has carried out or sponsored a number of studies that have appeared in the *Monograph Series* of the World Health Organization, the WHO series *Public Health Papers*, the *Bulletin of the World Health Organization*, and the *International Digest of Health Legislation*. Other studies have been published independently. A list of these publications is given below:

Monograph Series:

Bovet, L., "Psychiatric Aspects of Juvenile Delinquency," *World Health Organization: Monograph Series*, (1951), No. 1.

Bowlby, J., "Maternal Care and Mental Health," *World Health Organization: Monograph Series*, (1952), No. 2.

Carothers, J. C., "The African Mind in Health and Disease: A Study in Ethnopsychiatry," *World Health Organization: Monograph Series*, (1953), No. 17.[35]

Public Health Papers:

Baker, A. R., Llewelyn Davis, and P. Sivadon, "Psychiatric Services and Architecture," *World Health Organization: Public Health Papers*, No. 13.

Reid, D. D., "Epidemiological Methods in the Study of Mental Disorder," *World Health Organization: Public Health Papers*, No. 2.

Bulletins of the World Health Organization:

Guttmacher, M. S., "Medical Aspects of the Causes and Prevention of Crime and the Treatment of Offenders," *Bulletin World Health Organization*, 2(1949), 279.

Guttmacher, M. S., "Psychiatric Examination of Offenders," *Bulletin World Health Organization*, 2(1950), 743.

Macfarlane, J. W., "The Uses and Predictive Limitations of Intelligence Tests in Infants and Young Children," *Bulletin World Health Organization*, 9(1953), 409.

Tizard, J., "The Prevalence of Mental Subnormality," *Bulletin World Health Organization*, 9(1953), 423.

Geber, M. and R. F. A. Dean, "Psychological Factors in the Etiology of Kwashiorkor," *Bulletin World Health Organization*, 12(1955), 471.

Krapf, E. E., "On the Pathogenesis of Epileptic and Hysterical Seizures, *Bulletin World Health Organization*, 16(1957), 749.

Geber, M. and R. F. A. Dean, "Psychomotor Development in African Children: The Effects of Social Class and the Need for Improved Tests," *Bulletin World Health Organization*, 18(1958), 471.

Tooth, G., "The Psychiatric Hospital and Its Place in a Mental Health Service,"

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[34] Most of the reports of regional meetings which were "produced but not generally distributed" can be obtained on application to the respective regional directors.

[35] A further monograph, Buckle, D and S. Lebovici, "Child Guidance Centers," *World Health Organization: Monograph Series*, (1958), No. 40 has been referred to [31].

Bulletin World Health Organization, 19 (1958), 363.[36]

A special issue of the *Bulletin,* devoted exclusively to mental health problems, will be published in the near future. It will contain a series of papers prepared in connection with the fifth, sixth, seventh, and eighth expert committees (described earlier), and with the Study Group on Ataractic and Hallucinogenic Drugs in Psychiatry, also referred to earlier. A complete list of these papers is given below:

Bash, K. W., "Mental Health Problems of Aging and the Aged from the Viewpoint of Analytical Psychology."

Townsend, P., "Social Surveys of Old Age in Great Britain."

Sjögren, T., "Changing Age-structure and its Impact on Mental Illness, Especially Senile Psychosis."

Roth, M., "Mental Health Problems of Aging and the Aged."

Sandison, R. A., "The Role of Psychotropic Drugs in Group Therapy."

Sandison, R. A., "The Role of Psychotropic Drugs in Individual Therapy."

Jacobsen, E., "The Comparative Pharmacology of Some Psychotropic Drugs."

Kline, N., "Psychopharmaceuticals: Effects and Side-effects."

Lindemann, E., "Relation of Drug-induced Mental Changes to Psychoanalytic Theory."

Stengel, E., "Classification of Mental Disorders."

Sivadon, P., "Transformation d'un Service d'Aliénés de Type Classique en un Centre de Traitement Actif et de Réadaptation."

International Digest of Health Legislation:

World Health Organization, "Hospitalization of Mental Patients: A Survey of Existing Legislation," *International Digest of Health Legislation,* 6 (1955), 1.

Published Independently:

Apart from a number of articles that have appeared in scientific journals, mention should be made of the proceedings of the Study Group on the Psychobiological Development of the Child, which are referred to earlier.[37]

CONSULTANTS AND ADVISERS

As has been mentioned in the general introduction to this article, the World Health Organization, at the request of member governments, provides short-term consultants and long-term advisers. Between 1948 and 1959, nearly 30 countries availed themselves of consultant services, in some cases on several occasions, and six countries were provided with long-term advisers who stayed from one to three years. In certain cases, different long-term advisers also worked simultaneously or successively in the same country.

Further assistance to member governments was given by providing lecturers on

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[36] *The Bulletin of the World Health Organization* also published three papers on psychiatric problems in industry which were produced in connection with the work of the Regional Office for Europe in the field of social and occupational health and which are listed below:

Koekkebakker, J., "Mental Health and Group Tensions," *Bulletin of the World Health Organization,* 13(1955), 543.

Ling, P. M., "La Santé Mentale dans l'Industrie," *Bulletin of the World Health Organization,* 13 (1955), 551.

Mindus, E., "Outlines of a Concept of Industrial Psychiatry," *Bulletin of the World Health Organization,* 13(1955), 561.

[37] Independently published articles also were sponsored by the Regional Office for Europe, for example: Gibbens, T. C. N., "Psychiatry and the Abnormal Offender," *Medico-Legal Journal,* (Cambridge, England), 24(1956), IV.

mental health and allied subjects and by visits from members of the mental health staff of WHO Headquarters and regional offices.

FELLOWSHIPS

By October 31, 1959, the organization had granted 479 fellowships for the purposes of study and exchange of knowledge on mental health subjects to citizens of over 30 member States.

COLLABORATION WITH OTHER UNITED NATIONS AGENCIES AND NON-GOVERNMENTAL ORGANIZATIONS

The World Health Organization has collaborated on numerous occasions with other United Nations agencies. In some cases, headquarters and regional offices were represented by staff members at meetings organized by other agencies, and in other cases, representatives were specially appointed for such meetings. Staff members have presented a number of scientific papers at national and international congresses and conferences. Particularly close relationships were maintained with the (non-governmental) World Federation for Mental Health. Staff members have also participated in broadcasts and other activities devoted to the education of the general public in mental health matters. Special attention was paid to this latter activity in 1959 since, in that year, "Mental Illness and Mental Health in the World Today" was chosen as the theme of World Health Day. The issue of the WHO magazine, *World Health*, for May–June, 1959, was specifically devoted to mental health.

CONCLUDING REMARKS

It is to be hoped that the account of the work of the World Health Organization in the field of mental health that has been given in this paper may not only reflect what has been done in the last 11 years but also convey something about the principles which have inspired that work. Some remarks about the difficulties that arise in connection with the international approach to the problems of mental health were made in a paper which was published in the mental health issue of the UNESCO *International Social Science Journal*.[38] Here it may suffice to mention only two points of critical importance.

The first is that the battle for mental health cannot be won by psychiatrists alone. It requires consistent teamwork in which nurses, social workers, psychologists, teachers, ministers of religion, administrators, judges, employers, trade union leaders, journalists and many others can make important contributions. It is perhaps one of the greatest benefits of the international approach to mental health matters that it can show the psychiatrist the limitations of his own field.

The second point that should be stressed is that it is of fundamental importance to recognize the cultural and social differences between different areas and to take them into account in any recommendation for change that is proposed. As has been said in the paper just mentioned: "We may perhaps admit that everywhere in the world mental health presupposes an ability to perceive reality as it presents itself in the world and in the intimacy of the human being in an undistorted way, and a capacity for balanced action which manages to give satisfaction to both the physical needs and the cultural aspirations of the individual. But

[38] Krapf, E. E., "The International Approach to the Problems of Mental Health," *International Social Science Journal*, 11(1959), 1, 15.

international experience constantly reminds us that clear and full perception and harmonious action which is 'actualizing' the self at its optimal level do not always lead to 'happiness and effectiveness' in the Western sense, nor will they always and everywhere imply 'the ability to hold a job, have a family, keep out of trouble with the law and enjoy the usual opportunities for pleasure.' In fact, it teaches us even more: it makes us realize that even where ideals of the type just mentioned can be accepted as appropriate, mental health as a value can only be understood within the value system of which it is an integral part and should not be striven for without a clear awareness of its dynamic articulation with other values."

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Current aspects of psychiatry in Great Britain

Part 1

BACKGROUND

In the latter part of the last century, responsibility for the care of the mentally ill rested with the local authorities. Their interest was confined to those whose behavior was so disturbed that they were incapable of looking after themselves or became a danger or nuisance to others. With a few exceptions, treatment was purely custodial. It consisted of segregating the patients into huge, prison-like asylums, mostly situated well away from large centers of population. Here, there was little danger of their interfering with the normal business of society, and land was cheaper. Admission, needless to say, was often long-term or lifelong. These hospitals stand today—like obsolete battleships stranded on some remote sandbank—a formidable problem bequeathed by our Victorian predecessors. They were, however, providing one of the earliest of the welfare services, and certification was partly a method of demonstrating the need for a patient to receive care (Ministry of Health Report, 1958). That the hospital regime was rigorous or even penal was not surprising, considering the appalling living conditions of much of the outside population.

Some mental patients, however, through lack of asylum accommodation, fell within the province of the Poor Law and were accommodated in the workhouse infirmaries.

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Part 1 of this series deals with the historical aspects of the subject. Part 2, which will appear in October, will concern most of the important and recent developments in the field.

These were buildings whose size and character resembled the asylums although they were situated mostly within the larger towns. Here, these patients formed part of an agglomeration which included also the physically infirm, mental defectives, and those who were merely destitute. Sorting out the residue of this population is a process which is scarcely accomplished yet, although the majority of these institutions have been general hospitals for 12 years.

In the early part of this century, there developed a separate network of institutions in which most mental defectives were accommodated, following a series of acts regulating their care. The extent of the problem had become manifest for the first time following the introduction of universal compulsory education in the 1870's (Hargreaves, 1958).

These buildings, however, were few, compared with the lunatic asylums and Poor Law institutions, and it was not until the National Health Service that the responsibility for mental defectives was clearly established—resting on local authorities and regional hospital boards.

Up to the 1930's, this was virtually the totality of psychiatric services, apart from a small number of out-patient departments which developed mostly in teaching hospitals after World War I. Following the Mental Treatment Act of 1930, asylums (which were renamed mental hospitals) were encouraged to open their own outpatient clinics, but these were mostly limited to securing early, treatable cases as voluntary patients for admission.

SOCIAL LEGISLATION

In the period 1944–48, the welfare state came into being as the result of a series of measures which were based on the Beveridge Report. The Education Act was followed by a comprehensive National Assistance Act (which removed the last traces of the old Poor Law), by the Industrial Injuries Act, and by the National Health Service Act.

Under the National Health Service, all general and mental hospitals were absorbed into the state scheme and (with the exception of teaching hospitals) were placed under the direction of 14 regional hospital boards. The local health authorities continued to provide a number of public hygiene services, including health visitors, district nurses, ambulances, and accommodations for the elderly. They were given vaguely defined functions in the fields of preventive medicine and after-care but generally lacked the financial resources to carry these out effectively.

NATIONAL HEALTH SERVICE

In 1948, the National Health Service took over institutions which varied widely from one authority to another and inherited an acute shortage of trained psychiatrists and of other grades of qualified staff. Further, the mental hospitals were a service almost entirely divorced from the main stream of development in medicine—one regarded by the general public with fear and suspicion. The first major problem was, therefore, that of assimilating them into the general pattern of health services as a whole.

The situation had been worsened by the war, which caused a complete cessation, not only of all new hospital building, but even of routine maintenance. As a result of this, and of bomb damage, many hospital buildings were in a very bad state. There was little improvement in the post-war period of economic difficulties. Hospitals took a very low place in priority for capital development in comparison with defense, housing, power, schools, etc., and it is only

in the last few years that there has been real progress in this direction.

Moreover, the health service was being faced with a greatly increased demand for treatment in mental hospitals; admissions increased by 400 per cent in the period 1932–1957 (Cooper, 1958). Apart from the universal availability of free treatment under the National Health Service, many factors must have been concerned in this trend. The population was growing larger and becoming more urbanized; there had been widespread uprooting during the war, and its aftermath was a time of stress and privation; more out-patient clinics resulted in more patients being recommended for admission. The stigma of mental illness was decreasing at this time, and patients were coming forward more readily for treatment.

It may be appreciated, then, that the provision of full, modern psychiatric facilities for the whole country presented a truly Herculean task.

BREAKING DOWN OF BARRIERS

With the introduction of the National Health Service, the previous rigid segregation of mental hospital patients from the community began to lessen. A pioneer in this field was Warlingham Park Hospital, and in succeeding years, the same trend occurred throughout the country. Doors and gates have become unlocked; patients have gained greater freedom, both within the hospital and to go out for daily and week-end leave; strict separation of the sexes has been ended. The number of patients detained under certificate has fallen steadily, while those admitted voluntarily or informally have correspondingly increased. Many patients now go out to work from hospitals as a prelude either to discharge home or to entering a local authority hostel.

The ending of authoritarianism is a vital factor in the progress of psychiatric treatment. In the first place, it helps to prevent that institutionalization which produces the chronic mental patient and often rules out a return to the outside world (Barton, 1959). Secondly, it alters the relationship between hospital and community so that the hospital is no longer a place to be feared or despised.

MacMillan (1958) has pointed out that certification encourages the members of the community to regard the mental patient as a person apart from themselves, and that no true therapeutic relationship can develop when the patient is legally inferior to the doctor or nurse. The same point has been emphasized by Mandelbrote (1959): "For the mental hospital to play its role effectively, it is very important to provide an internal psychotherapeutic atmosphere within the hospital; this, in turn, will have the function of further enlightening an informed public opinion in the community."

The principle of the custodial institution has been replaced by that of the "therapeutic community"—one in dynamic equilibrium with the community outside.

However, it has recently been pointed out by the Ministry of Health that some patients will remain for whom the maintenance of adequate security precautions is an essential part of their hospital care. Public confidence in mental hospitals and their present open-door policy might be shaken if serious incidents occurred, involving patients whose mental state was such that they should have been detained. To avoid this, it is suggested that either each hospital should maintain special security precautions in part of its accommodation, or that regional units should be established for certain classes of patients.

ROYAL COMMISSION

In 1953, Sir Winston Churchill announced in Parliament that there was to be a Royal Commission to inquire into the law dealing with those suffering from mental illness and mental defect. The commission received evidence from over 100 British associations, societies, local authorities, hospital authorities, and government departments. Most of the witnesses were unanimous in their wish to have new legislation to replace the old Lunacy Act, Mental Treatment Act, and Mental Deficiency Acts, which incorporated out-dated assumptions and attitudes.

The report of the Royal Commission in 1957 had two broad themes. It sought, first, to abolish the administrative and legal distinctions between mental and other forms of illness, and, secondly, to shift the emphasis from treatment within the hospital to treatment within the community. It made recommendations for the law to be altered. Whenever possible, care should be provided for mentally ill patients with no more restriction of liberty or legal formality than for those needing other types of care or treatment. Compulsory powers were to be used only when positively necessary.

The report was well received on all sides and acclaimed as a great social document. It established a clear need for new legislation and provided a blueprint for the Mental Health Act of 1959.

A NEW ERA AND LEGAL CODE

One of the earliest reforms in the treatment of the mentally ill was the removal of their chains, and the latest, the Mental Health Act, releases psychiatric patients from some of their legal fetters. The Lunacy Act of 1890 used to be the principal law regulating the treatment and detention of the mentally ill. The Mental Treatment Act of 1930 made it possible for people to obtain treatment in mental hospitals as voluntary patients without certification and contributed to a marked improvement in mental hospital practice over the past 25 years. The 1959 Act marks the beginning of a new era, will abolish the former certification procedure, and ensures that the majority of psychiatric patients will be admitted informally, with no more restriction than is applied to patients in general hospitals.

The new Mental Health Act provides for a single legal code to cover both mental illness and mental deficiency. Thus, the Lunacy Act, the Mental Treatment Act, and the Mental Deficiency Acts are abolished. The new act sweeps away the former designation of certain hospitals for mental illness or mental deficiency, so that any—including general hospitals—may in the future accept psychiatric patients. An increase is, therefore, expected in the treatment that will be available for psychiatric illness in general hospitals.

Some of the legal definitions in the old codes have been happily removed from official terminology. The term "mental disorder" will cover all forms of mental illness and disability. For the purpose of compulsory detention (to be used only as a last resort), the act recognizes four groups: the mentally ill, the severely sub-normal, the sub-normal, and the psychopathic. The term "severely sub-normal" deals with the more handicapped and the term "sub-normal," with some patients previously classified as "imbecile" or "feeble-minded." Psychopathic disorder is defined as "a persistent disorder or disability of mind (whether or not including sub-normality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient and requires

or is susceptible to medical treatment." Even the legal definition of a psychopath was a problem of the utmost complexity, and the inclusion of this category is a new feature to British mental health legislation. Most implications in relation to treatment have still to be worked out.

The new procedure for compulsory admission to a hospital is to be used only when every available alternative method has been considered. It dispenses with a judicial order (except in criminal court cases) and requires, instead, two medical recommendations, one of which has to be made by a specialist in psychiatry.

SAFEGUARDS

There are two important safeguards in the act against improper detention. One is the two medical recommendations, already referred to, which are needed in all cases except emergencies, when one will suffice for the first 72 hours. The second is that patients compulsorily detained can apply for their release to Mental Health Review Tribunals any time within six months of admission. These tribunals will be less remote and more accessible bodies than the Board of Control, whose good work at the Ministry of Health is to be brought to an end. One tribunal will be set up for each of the hospital regions and will consist of legal, medical, and lay members with experience in administration or knowledge of the social services. The tribunals will have wide powers to consider applications for the release of psychiatric patients compulsorily detained—either from the patients themselves or from their relatives—and will also have power to discharge them.

There are other changes with respect to power of discharge. The general rule remains that the nearest relative of all patients admitted under the new procedure will hold this power, except for those detained under court orders. Powers of discharge are also given to the doctor responsible for the patient's treatment, to the hospital managers, and to local authorities in cases of guardianship or patients detained in private nursing homes.

EMPHASIS

The Royal Commission Report and a previous report of the WHO have drawn attention to the fact that admission to a mental hospital should be considered as an episode in the care of the patients, to be resorted to only when treatment can be given in no other way.

This aspect is being taken into account in the development of British mental health services and is illustrated by the enormous growth of psychiatric out-patient attendances and by the development of day hospitals and community care services. All these changes emphasize the trend away from in-patient treatment but also make it necessary to think of social conditions in the community outside. "We need the willingness to study the structure of our society itself, in which it becomes possible to break down in mental health, and see how far it is necessary to alter society rather than adapt the individual to fit society's demands" (Kahn, 1958).

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Summer camping in the treatment of ego-defective children

The problems involved in the social and psychological treatment of disturbed children have led practitioners in the field of mental hygiene to search constantly for new treatment methods and facilities. Group therapy and social group work have been added to individual psychotherapy, and paralleling these developments has been the growth of year-round residential treatment of various types. A relatively recent development has been the use of the summer camp for therapeutic purposes.[1] Although still modest in its scope, the trend toward summer camping as an adjunct to therapy is likely to increase.[2] Several camps in various parts of the country have been set up specifically to serve disturbed children and others with special needs. Also, some agency camps are enrolling these children in small numbers with regular campers in an attempt to further their socialization.

An early attempt to describe the thera-

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[1] An interesting description of one of the first treatment camps is found in Rademacher, E. S., "Treatment of Problem Children by Means of a Long-Time Camp," *Mental Hygiene* 42(April, 1958), 385–94.

[2] The nature and extent of present-day therapeutic camping is discussed in McNeil, Elton E., "The Background of Therapeutic Camping," *Journal of Social Issues*, 13(1957), No. 1.

peutic rationale of summer camping was made in a perceptive article by Hallowitz.

> "If the child's behavior and needs are understood, and he meets with tolerance, warmth, and encouragement from the counselor, he will soon realize that this adult is different from his own parents. Old patterns of adjustment will no longer be necessary. New ones will come to the fore. Healthy and mature responses can be encouraged, and infantile and unwholesome patterns discouraged. The counselor becomes like a parent, and the child has an opportunity to relive his early, formative years in which the parent's love or denial of love is so important in his training. The child now begins to make appropriate responses and can exercise control over his asocial impulses, not through fear of punishment, but in order to please and gain the love of the parent (counselor). While at first these new patterns are created just to please someone outside himself, later they are incorporated and become part of his own demands on himself."

This, of course, represents an idealized model of the therapeutic process that may occur in a camp setting and does not adequately reflect some of the technical problems involved in dealing with disturbed children. Subsequent experience in therapeutic camping has given us a clearer picture of these problems and has indicated that it is unrealistic to anticipate the achievement of such dramatic results with most disturbed children in the rather short period involved in summer camping.

THE DISTURBED CHILD'S PROBLEMS AS A CAMPER

The difficulties in work with disturbed children at camp are great. Even the relatively stable child is subjected to many unaccustomed strains in this setting. The isolation of the usual camp site and the presence of strange and unknown objects in the woods, as Redl points out, are likely to activate fantasies and stimulate fears.[4] To these tensions are added those occasioned by the requirement that the child relate closely and with a minimum of friction to a large number of peers.[5]

The disturbed child must face even more. He has to contend with the panic which separation and a new setting and people usually engender in him. He is called upon by the nature of the situation to carry out functions which demand a great deal of control; he must share an adult with many others, tolerate a number of unaccustomed routines, and weather the mistreatment which will inevitably occur at some point during interaction with any group of children. These are facts which cannot be overlooked in any discussion of the advisability of camping for disturbed children.

THE IMPORTANCE OF SELECTIVITY IN CAMP INTAKE

Consideration of the potentialities of camping for disturbed children must also involve some discrimination among levels of disturbance. Not all of these youngsters respond in a similar fashion to camping, nor do all have the same ability to make use of it. Hallowitz, even while emphasizing the value of camping for disturbed children, cautions us that some of them are not ready for this experience. "Some children," he writes, "need a more controlled and repressive environment; others suffer from too close an association with members of the same sex, and still others are too disturbing to their fellows, so that while they benefit from the experience, they min-

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[3] Hallowitz, Emanuel, "Camping for Disturbed Children," *Mental Hygiene*, 34(July, 1950), 409.

[4] Redl, Fritz, "Psychopathologic Risks of Camp Life," *The Nervous Child*, 6(No. 2, 1947).

[5] The highly charged atmosphere in which this must usually be accomplished is discussed in Schwartz, William, "Camping and the Group Experience," *Group Work Papers* (Chicago: Group Work Section, Chicago, Ill., Chapter, National Association of Social Workers, 1958).

imize or even destroy whatever benefits the other children might receive." [6]

As awareness of this point has increased, some treatment camps have become more selective in their intake.[7] Faced with limitations on size of staff and on numbers of counselors with appropriate backgrounds and training, they have found it wise to take as campers only those disturbed children whose egos are not greatly damaged. As Staver and her colleagues have written: "The interaction of the camp group is robust, and even a proportion of about one adult to two children is not sufficient to allow long-time individual supervision of the more disturbed child. For these reasons, we feel that children who are too disturbed to achieve any real integration with the group or to get along without virtually full time individual supervision should not be accepted." [8]

NEED FOR EXPERIMENTATION WITH MORE SERIOUSLY DISTURBED

It would be unfortunate, however, if the cautions just cited were to lead to overly rigid intake policies for camps interested in helping disturbed children or to a refusal to undertake new ventures with the more deeply disturbed among them. It is important that agencies continue to investigate the potentialities of summer camping as a medium of service and treatment, not only for those disturbed children who have displayed some tolerance for group association and whose egos are relatively intact, but also for ego-defective children whose capacity to relate in groups appears to be substantially below average.

A CAMPING EXPERIENCE FOR A GROUP OF EGO-DEFECTIVE GIRLS—FIRST SUMMER

In the summer of 1955 the Department of Neighborhood Clubs of the Boston Children's Service Association was presented with a special opportunity to study the reactions of several ego-defective children to camping. Among the clubs which had been conducted by the department during the previous winter and spring was one group composed of several teen-age girls who, at the time of their referral, had displayed a marked inability to relate to their age-peers or adults. The girls had been together for seven months prior to the summer. During that time they seemed to find satisfactions in some of the activities and the relationship with the leader and had been able to remain together as a group. Occasionally, they functioned surprisingly well as a unit. Their ways of relating were still quite primitive, however, and their behavior, by and large, continued to reflect severe impairment of ego-functioning. The department staff, while aware of the pitfalls, felt that it would be worthwhile to explore the reactions of this group to camping in order to determine whether under special circumstances—including a common group experience prior to camp and the group leader present as a camp staff member—it would not be possible for these ego-defective girls to remain at camp over an 11-day camping period and make constructive use of the experience without interfering with whatever benefits the other campers might receive.

The department's summer camping operation reflects the basic aims of our service

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[6] Hallowitz: *op. cit.*, pp. 419–420. See also Aldridge, Gordon J., and D. Stewart MacDonald, "An Experimental Camp for Emotionally Disturbed Boys," *Journal of Child Psychiatry*, 2(1942), Sec. 3, 251.

[7] See Staver, Nancy, Manon McGinnis, and Robert Young, "Intake Policies and Procedures in a Therapeutic Camp," *American Journal of Orthopsychiatry*, 25(January, 1955), 148–61.

[8] *Ibid.*, p. 154.

and the approaches to group composition we employ in our year-round work. The department provides a group work service for physically handicapped and/or emotionally disturbed children who are experiencing marked difficulties in their social relationships.[9] Children are referred to the department by casework, educational, group work, medical, and psychiatric agencies. Usually they are referred individually by agencies and a group of relatively normal children is formed around each of them in his or her own neighborhood. Sometimes, however, several disturbed or handicapped children are referred together and accepted for service as a group.

At camp, as in the year-round program, we are interested in furthering the integration of disturbed or handicapped children with their "normal" peers wherever this appears to be feasible and clinically desirable. Each child attends camp with his own club, and the members of several clubs attend each camping session together. In this setting, even if his own club group is composed entirely of other handicapped or disturbed children, the handicapped or disturbed child is brought into close contact with a number of youngsters who are relatively normal and stable.

The camp itself is located 25 miles from Boston. At the time material for this paper was collected, it was conducted on a single sex basis, with about 25 children from four or five different clubs, all of the same sex, but of different ages, attending each camping session together. These camp sessions were brief, being only 11 days in duration. The physical area of the camp comprised 13 acres. The staff included three regular department workers as director and supervisors and eight other counselors, all of them students in social work or related fields.[10]

The group to be studied was composed of five adolescent girls, two of whom were in the borderline or psychotic categories, and four of whom had severely damaged egos. This group had been formed on a trial basis after considerable discussion among school guidance personnel and the department's staff and psychiatric consultant.

The original member was Andrea, age 13, who had been referred by a casework agency where her mother was being seen. An only child, both of whose parents worked, Andrea had been raised by a very disturbed grandmother living in the home. When she was eight, her parents had placed her in a residential treatment center. Three years later, against the advice of the center's staff, they brought her home and enrolled her in public school where she was assigned to a special class. Here she was extremely aggressive and had to be put on a three hour a day schedule. At school, repeating the pattern she had displayed at the treatment center, she functioned as an isolate and made no friends in or out of class. Tests revealed an I.Q. of 82, although it was felt this was well below her potential. Andrea's emotional problems were complicated by a mild spastic condition.

The other members had been selected by the school guidance department from special classes. Each had at some time ex-

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[9] The nature of the department's practice is discussed in Kolodny, Ralph L., "Research Planning and Group Work Practice," *Mental Hygiene*, 42 (January, 1958), 121–132.

[10] Since that time, the system has been changed to include both boys and girls at each session, and the acreage has been enlarged. The camping period has been extended to 18 days and the number of campers and staff has been increased. The department's camping practices are reviewed in Kolodny, Ralph L. and Virginia M. Burns, "Group Work with Disturbed and Handicapped Children in a Summer Camp," *Social Work with Groups* (New York: National Association of Social Workers, 1958).

pressed a desire to participate in some kind of group, but because of poor or inappropriate ways of relating to others, had experienced little association with other youngsters. These other members were: Genie, 12; Grace, 13; Dolores, 13; and Janine, 16.

Genie was a seriously retarded youngster who also suffered from a hearing loss. She had been in special class since first grade and was friendly only with five and six-year-olds. She was resentful of her intellectually normal older sister. Obese, withdrawn, and slow moving, Genie frequently appeared depressed and inert.

Grace was receiving casework help at the time the group was formed. Rejected by her mother, she was oppressed by marked feelings of inadequacy. She had *petit mal* epileptic seizures. Although quite normal in her speech and outward appearance, Grace was unable to read. Physically she was quite attractive and, as the club began to function, she exhibited more maturity in social relationships than did the other members.

Dolores was the most obviously "different" of all the members. Her speech and gait were infantile and in her conversation, which was often irrational, she exhibited a preoccupation with fears of death, blood, direct and physical pain. She had been seen once a week at a child guidance clinic for three months but had been taken out of treatment by her mother.

Janine had been afflicted with polio-encephalitis at the age of nine. Her speech and toilet habits were severely affected as a result, and she was left with a paralysis of the right arm. After several years of special schooling, she re-entered public school. Placed in a special class on the basis of an I.Q. of 75 she began to show signs of extreme confusion. Her disturbance became acute, and she was committed to a mental hospital where she was diagnosed as schizophrenic. She returned to public school after discharge several months later and was now receiving casework on an out-patient basis. At her own request Janine was living with her grandmother, being unable to tolerate her brothers and sisters.

The results of our study of the behavior of these girls during the summer of 1955 have been reported in detail in an earlier publication.[11] Their first summer at camp was a stormy one for them. The stresses of the experience produced severe reactions, particularly during the first several days. A kind of group fragmentation occurred as each member became preoccupied with her own survival and paid little attention to others. Andrea sought out counselors rather than campers, but related to both primarily through bursts of hostility. She was obviously angry with her club leader, who was camp director, for not giving her enough attention. A counselor had to be with Janine constantly during the first two nights as she was very apprehensive and hallucinated, hearing bombs and sirens. Grace stayed in the kitchen most of the time, repeating the role she played in her own family and ate and worked with the kitchen staff. It was not until the third day that she felt secure enough to give up the protection of this isolated position. Dolores frequently stuffed dirt and stones in her mouth in the manner of an infant. Genie refused to eat the first meal and initially spent most of her time sitting and watching in hostile silence.

The intensity of their initial reactions diminished, however, as time went on and there was observable movement on the part

[11] See Kolodny, Ralph L. and Virginia M. Burns, "Specialized Camping for a Group of Disturbed Adolescent Girls," *Social Work*, 1(April, 1956), No. 2, 81–89.

of several of these youngsters toward an adaptation to camp. Andrea moved slowly in the direction of less suspicion of adults and during the last three days, especially, her belligerence decreased perceptibly. She formed a friendship with an older withdrawn girl from another club, permitted affectionate gestures by counselors, and even made affectionate overtures to them. At the end of the camp period she told her cabin counselor that, although part of her wanted to go, part of her wanted to stay. Despite her resistance and withdrawal, Genie, too, was able to reach out somewhat. She became particularly friendly with two passive youngsters, age 11 and 9. Before she left, Genie told the director that she wanted to stay at camp "forever." Grace, toward the end, came to seek approval through her performance in program activitives and gave up acting as flunkey to several older girls, something she had done earlier. She made friends with some of the more passive campers her own age. In contrast to her frequent expression of disappointment with activities during the year, she was able to say that she had enjoyed camp. Even Janine, after seeing her caseworker on visitors' day, seemed to be less overwhelmed by her depressions, although she often appeared quite unhappy. She began to go swimming daily, expressed an interest in doing things for the camp carnival, and participated briefly in a small dramatics group composed of three campers and a counselor. Janine later wrote from home asking if she could some day come back to camp as a counselor. Of all the members, Dolores gave the least evidence of positive change in any respect. She continued throughout to eat sand and dirt and spoke constantly of her fears of height, blood and death. She resisted or was oblivious to routines and activities and occasionally disrupted the latter. She did, however, become less fearful of undressing in front of others or being seen in the bathroom. She also became less confused in her attempts to distinguish among different people at camp.

Thus, for all its difficulties, and despite its brevity, there were several indications that the camp experience was valuable to the girls. None of them pressed for a return home; the early crisis aspect of the situation was worked through to some extent; some positive behavior emerged as time went on, and all of the girls expressed a desire to return.

It should also be noted that the other campers, with the exception of two very aggressive and provocative girls, were able to tolerate the behavior exhibited by the members of this group. Whatever tension occurred was not expressed through the direct scapegoating of these girls but rather through the displacement of hostility or demanding infantile behavior and never reached an unmanageable level. Open rejection or ridicule of the girls was extremely rare, and many campers imitated staff in their manner of approaching or speaking to them. Occasionally, other campers would try to involve one of these girls in an activity. In a few instances, friendships were made between them. Despite the anxieties aroused by exposure to odd or bizarre behavior, campers seemed to feel fairly comfortable in this setting.

The behavior these girls exhibited during the year which followed the first camp experience was by no means consistent. It varied, of course, from member to member. Much of it, however, appeared to indicate progress. Andrea had her school hours extended after she indicated by her behavior that she could tolerate this. Dolores' bizarre behavior continued, but the school psychologist who tested her every year saw a lessening of some of her paranoid and schizoid tendencies. Although members, individu-

ally, continued to sometimes appear hostile and depressed at meetings and to respond ineptly and inappropriately to events, they were able to function more adequately as a group. They showed themselves capable of taking greater responsibility for planning their own programs. They appeared to make some progress toward being able to talk out rather than act out some of their upset feelings. All of them came to a camp reunion in the fall and Andrea, Grace, and Dolores participated extensively in the singing and games. They spoke of camp often during the year and appeared to look forward to attending again the next summer.

SECOND SUMMER

We realized that, although these girls had profited from the experience in some respects, the gains they had made during the first summer's session were modest, and we were very much aware of the difficulties they had presented to staff. Despite this we decided to bring them to camp a second time.

There were a number of new counselors and many new campers the second summer which meant that once again these girls had to relate to quite a few unfamiliar children and adults.[12] Unlike the previous season, however, in addition to knowing the director well, they were acquainted with five other adults (two supervisors, one counselor, and the cooks). The staff, in turn, contained four people who knew the girls, their problems and capacities, fairly well and who felt relatively sure that their behavior could be managed.

The behavior of these girls during the second summer indicated that our decision to take them back to camp was a sound one. While tension persisted and was sometimes severe, by and large this was distinctly a more successful session than the first. It appeared that the camp experience was now less stressful for the girls and that some accommodation had taken place. Of course, their behavior was by no means uniformly positive. Many of the maladaptive patterns seen the first summer reappeared, and their reactions were erratic. Attempts at inner control and greater amenability to involvement in camp life, however, were now more in evidence.

Andrea, who, the previous season, had immediately reacted to the stress of camp with violent outbursts of temper and verbal tirades, was initially considerably more subdued. Upon arrival at camp she could not refrain from a few hostile comments, but also asked to see the cooks whom she kissed warmly.

As the camp season progressed, she would often turn to sarcasm when her feelings became too threatening. At the same time, she could directly seek the approval and affection of counselors. It is significant that she did not slap at them as she sometimes had at the beginning of the first summer and instead very frequently sought to hold hands with them. While the violence of her anger was considerably diminished, she was not able to deal too adequately with her ambivalence. Sometimes, for example, she was very affectionate with her cabin counselor, but at other times she would complain that the counselor made her "sick." She could not yet trust her own feelings of affection and had to test out adults to see whether their expressions of positive feelings towards her were genuine. In contrast to the summer before, she was able to evince an interest in contacts with male counselors. She turned to

[12] One of two girls who had been added to the group during the year also came to camp. This was Cynthia, a very large and aggressive 13-year-old who had been and continued to be very difficult to work with.

them for play as eagerly as she did to female counselors and, instead of scornfully disclaiming any concern with males, spoke of the fiancee of one male counselor as "the luckiest girl in the world."

Andrea rarely complained about work assignments the second summer. She griped about extra work details but was able to appear for and carry out regular work assignments. The first summer she had begun by inveigling another youngster into taking her place at dishwashing. She did not repeat this. She did have a tendency to sometimes slip off and avoid work but, when urged by other campers, she worked quite well. She carried out all her assigned tasks and did her part regularly in cleaning the lavatory, sweeping the dormitory and the like, even when she clearly did not want to.

She was ready to participate more readily in camp program and seemed to derive more gratification from the activities despite her continued low frustration tolerance. Her preference was still for individualized activities in which she could play along with the counselor, but she derived some enjoyment from group activities such as singing and occasionally became quite enthusiastic at "sings" during evening programs. She even played the piano for a group on one occasion after volunteering when another youngster was unable to play a particular song. She had never before revealed her ability in this area. Andrea also joined the camp discussion group, which involved sharing ideas and feelings on problems of getting along with others, and was a regular member.

In the beginning, Janine continually sought contacts with counselors and invariably attempted to use these contacts solely for the purpose of discussing her feelings of depression and inadequacy. During the first few days, her communication with other campers was negligible, and although they said little about this, they did begin to stare at her as she walked about with her head down, obviously quite unhappy.

Despite her deep and persistent depression, Janine did begin to respond more positively in some respects as time went on. She became particularly interested in the camp discussion group led by the director, and as this got underway, she displayed less and less of a need to seek individual conferences with counselors.

On only one occasion did she come close to repeating the distraught behavior of her first two evenings of the summer before. This was on the seventh night of camp when she became panicky after one of her roommates, a youngster from another group, told a frightening mystery story. The director, who was called, was able to quiet her by firmness and reassurance, and Janine did not subsequently repeat this acute behavior, although she was frequently depressed.

Toward the end of the period, Janine found a source of gratification in the camp dramatics group. The previous year she had participated briefly in a small group of three campers who had talked together about dramatics, but her interest had not been sustained. The second summer she joined the new dramatics group and took a prominent part in its activities. Although frequently shaky and fearful of failure, she was willing, with support, to undertake a substantial role in the camp play. In the actual performance she acted well and received much praise from the other campers.

While Dolores' confusion and anxiety were always apparent, her conversation and behavior during the first several days indicated that she was making some kind of conscious effort to change. A number of times she said to counselors, "Last year I did strange things, but now I'm older.

Last year seems like 15 years ago." Except for the first day, when she ate sand once, she did not eat dirt or anything similar for the entire period. She did not play with her food at meals, messing and blowing it about as she had frequently done a year earlier. Although she displayed the same fear of undressing in front of others as she had the first summer, she did not show any particular fear of going to the bathroom. Unlike the year before, it was not necessary to ask other campers to stand guard at the bathroom door to make sure no one would intrude upon her.

For a substantial part of the period Dolores participated better in activities than she had the year before. Although the range of programs she engaged in was still extremely narrow, she did a little individual crafts work on her own initiative and actually participated in some group activities. She enjoyed outings, for example, and joined in now, although not loudly, on singing, whenever it occurred. Although athletics frightened her, she occasionally participated in such things as relay games. There were signs of strain in her behavior during the second half of the period and, after visitors' day, when her family did not appear, she regressed perceptibly, messing more with her food at meals, squinting and staring more often and complaining that others were staring at her. Even then, however, she did not withdraw from activities to the extent that she had the first summer, and she never became disruptive as she had at that time. Surprisingly, Dolores was among those who joined the discussion group. Although her comments were at first focused solely on herself, she later was able to relate to the problems others brought up and to make suggestions for their solution.

In contrast to the summer before, Grace was able to participate in camp life without first isolating herself. At that time, it will be remembered, she had devoted the larger part of the first two days to working in the kitchen and had taken her meals there. Now she made no move to do so. On visitors' day she actually articulated this new feeling of comfort. When her mother asked her if she had been helping in the kitchen, she said this summer she didn't have to because she "had more friends" and was "having more fun."

Her feelings toward members of her own club group were marked by ambivalence, and her behavior toward them oscillated. For the most part, she was attracted to members of other club groups and even at night expressed a desire to stay in a room occupied by another club. At the same time, in some instances when derogatory remarks were made about members of her own group, she defended their reputations. Most of her contacts with her own club were after lights-out when she joined in heartily on their discussions. Initially, she sought out high status campers and became closely involved with one rather sophisticated-appearing girl with whom she was seen to engage in sexual play on one occasion. By mid-period, however, this youngster and Grace had moved apart without any outside intervention.

Genie's personal appearance continued to reflect her poor self-image, and there was no alteration in her addiction to dirty, masculine attire. She did show change in other respects, however. She participated more in activities, and while she clearly preferred to play alone with a male counselor, she was occasionally willing to play active group games when invited. Toward the end of the camping period she worked very hard at crafts for two days, making two well-constructed ring boxes, one for herself and one for another girl. After the first four days she did not resist being on

time for meals and did not lag far behind the other campers as she had the year before. Although she sometimes complained about work details, she departed from her old pattern by carrying out extra tasks in order to gain attention from counselors.

The actions of some of the members of this group were, naturally, sometimes threatening to others. Campers were worried about Dolores' odd manner and conversation and occasionally expressed anger toward her over such things as her work performance during clean-up. They rarely, if ever, initiated contact with her. Janine's depressed aspect was unpleasant for them. Andrea was resented at times because of her sarcasm, and some campers felt she was being given too much attention by the director.

In general, however, the behavior of the members of this group was not intolerable to the other campers. Grace and Genie developed friendships with girls from other clubs. Occasionally, other campers were protective and supportive toward Dolores, helping her to learn a game or sympathizing with her when she was criticized. The entire cast was openly supportive of Janine and helped her to mobilize herself when she had difficulty during preparation for the camp play. It is particularly noteworthy that the other seven girls in the camp discussion group made plans with Janine, Andrea, and Dolores to have a "social" after camp and also asked if they could meet as a discussion group during the winter.

Assessment of the Experience

In evaluating the overall effect of the camp experience on these girls, the emotional gains must be weighed against the amount of anxiety which the experience itself engendered. There is no doubt that it was a trying experience for them. This was particularly evident during the first year when the shock of separation from familiar surroundings and exposure to a relatively strange milieu initially produced dramatic signs of panic, withdrawal, and aggression. Because of the catastrophic intensity of their reaction, much of their behavior was characterized either by a direct expression of intolerable tensions or a protective avoidance of involvement in camp life. Socialization was, to a large extent, limited to anaclitic relationships with counselors. However, clear cut indications of recovery from this initial reaction were seen even during the brief period of their first stay. It seemed highly significant that all had strong reactions to leaving camp and expressed the wish to return the following summer.

Improvements in adaptation to camp were noted during the second summer despite the persistence of disturbed and inappropriate behavior. These girls were able to make wider use of program activities. Disruptive behavior on their part decreased. Their need for individual attention from counselors diminished, and they appeared better able to tolerate limits on their demands for this attention. Although they still had relatively little contact with other campers, three of them were willing and, in some ways, eager to be with other campers in the discussion group. Here, they were able to share the discussion leader with other youngsters, to wait their turn in conversation, and to reveal their personal feelings despite their fantasies of what this might mean in terms of exposure of problems and rejection. All of them, in varying degrees, appeared to have improved in their ability to control impulses, and for long periods they clearly exercised restraint in acting out their feelings. During the

second summer, while they still showed the effects of dislocation, they responded to the demands of camp life with less distress and seemed able to derive more pleasure from the experience.

These girls were able to maintain themselves in the camp situation and improve in their responses to it, because the staff was able to tolerate and manage the acute and distressing reactions they displayed. As a result, while they did precipitate crises, the consequences of these crises were never disastrous, and the outcomes were sometimes emotionally beneficial.

The Management of Crises

For any child there are points of stress in a camp experience which are capable of disrupting his defenses against anxiety and producing disturbances in behavior. These disturbances, however, are usually neither too severe nor frequent and can ordinarily be handled with sympathetic reassurance by counselors who are accustomed to dealing with such minor emotional upsets. Ego-defective children, however, because of their extreme vulnerability, may react catastrophically to the same stresses and precipitate management crises. Since these children have such limited capacity for sublimation, relatively little use can be made of program activities in draining off their anxiety, and this results in extraordinary demands on the counselors. These demands are not only in terms of their time and energy but also in the burden of anxiety that is imposed on them. Counselors must be equipped and willing to face the extreme reactions which accompany ego collapse, including panic, severe depression-extreme regression, and even temporary loss of reality testing. Because of the extreme pressure to which counselors are subjected, it is essential that they be given a realistic appraisal of the kinds of problems they will face and then provided with the necessary emotional supports by senior staff.

It is possible to reduce the frequency of acute reactions by buffering the ego-defective child from severe psychological shocks through the flexible use of staff and program and alertness to emotional danger signals. Regardless of the amount of planning that goes into the organization of the program, however, it is impossible to eliminate all psychological hazards. The aim of the staff, therefore, should be to reduce the traumatic impact of crises and, through proper management, use them to provide corrective emotional experiences for the child.

Crises can be anticipated around those events in camp life which characteristically increase anxiety such as initial exposure to the setting, being subjected to new routines, the introduction to unfamiliar food, being required to sleep in strange surroundings, and the like. Because of the severe pathological behavior of such youngsters, however, it can be expected that they will overreact to even the minor tensions of camp life.

The examples which follow illustrate the extreme loss of ego-control that can occur in such children as well as their capacity for recovery when given sustained support by someone who is sensitive to their needs:

Paranoid reaction as an outgrowth of religious sensitivity. During the second camp session, Andrea, who is Jewish, complained from time to time that Jewish campers were being discriminated against. Extremely ambivalent toward her own Jewishness and very much concerned with exposure and difference as these related to all aspects of her life, she began to see anti-

Semitism all about her. When the other three Jewish campers did not support her contention, she became more upset. This came to a climax on Friday evening when she became preoccupied about the fact that there was no Jewish service. The following day, Andrea went to the director, who provided her with an opportunity to ventilate her resentments. The intensity of her feelings increased as she talked, and she went on to point out ordinary comments and exchanges of glances on the part of others as being evidences of prejudice; she also bitterly attacked the camp's nondenominational services as discriminatory. She remained adamant in response to the director's unruffled acceptance of her hostility and willingness to make adjustments, maintaining that the administration as well as the other campers were hostile toward Jews. Instead of continuing to deal with this rationally, the director responded to Andrea's feelings of isolation and her fear of surrendering her identity. As a result the fury of Andrea's tirade diminished, and she broke into tears. The director put her arm around her, and Andrea allowed herself to be comforted. The next morning, Andrea went to the non-sectarian service. A Jewish counselor had been delegated to help in planning the service, and the program was arranged with Andrea's complaints in mind. Andrea sat through the entire service, and her only comment on leaving was, "There wasn't anything wrong in that. It couldn't hurt anybody." She was tranquil for the rest of the morning, and there was no recurrence of this particular problem.

Loss of ego-control accompanied by hallucinations. Janine, who had previously been hospitalized with a diagnosis of schizophrenia, managed to control her anxiety during the first day of camp by adopting a facade of maturity. She came prepared with 10 packages of cigarettes and, cigarette in hand, she affected an urbane manner. On the surface this was so successful that one of the children mistook her for a counselor. The staff was also deceived by her apparent poise, and on the very first night, underestimating her fear of exposure and need for anonymity, ill-advisedly attempted to include her in informal dramatics. This proved too threatening, and Janine fled from the room and remained outside, smoking incessantly, until the activity was over. As bedtime approached, her anxiety increased. She was unable to sleep and sat immobile on her bed. She seemed so tense that the director, who had come into the dormitory, decided to take her out for a walk. She asked Janine if she were homesick and wanted to go home, to which she replied, "I don't know where I want to go." She could only talk about how frightened she was, and the director suggested that she might be afraid that she would break down again. Janine was taken aback at the fact that the director had known she had been hospitalized, and she wanted to know if the other campers were also disturbed. Clenching her hands repeatedly, she began to talk about being a failure, saying that no one liked her or understood her. She said she had no friends so she made them up. She talked about hating her family and, running throughout the rest of the discourse was the theme of hating doctors, because they left her constantly, and liking social workers, because social workers listened to her and helped. She described with intense anguish her fear of being abandoned. The director encouraged her to ventilate her feelings and made it plain that she and staff understood how Janine felt and could accept her behavior. She reassured her they would not punish her by

sending her away from camp. Janine's agitation gradually subsided, and the director was then able to take her back to the cabin where she went to bed.

On the second day, Janine woke up appearing to feel pretty well. She participated in crafts and was able to make some conversation with children at the table although there were periods of depression during the day when she appeared not to hear what was being said to her. That night there was a costume dance, an activity which Janine again found distressing. She did not appear in costume and seemed extremely sad. She said that she was tricked into coming to camp and refused to participate in the activity. Counselors would come over to her to talk with her from time to time, but she would sit blankly as if she did not seem to hear them. Tears started to stream down her face, but outside of this, she exhibited very little affect. By the end of the evening, she was sitting next to her cabin counselor, crying. At bedtime, some of the others in her sleeping quarters tried to console her. She banged her head on the bed and became incoherent and, unlike the night before, did not respond to the director when she came in. She hallucinated, hearing bombs and seeing bad men coming to get her. The director, who was alarmed over the severity of Janine's reaction, called the assistant director and, in Janine's presence, mentioned something about perhaps telephoning the doctor. Janine became even more upset at this and pleaded with her not to call the doctor. She kept asking for her own cabin counselor and did not want the assistant director, a man, around. The director and counselor then sat with Janine. They told her they were not planning to have her hospitalized but wanted to talk with the doctor in order to help her. During this time she kept hallucinating, hearing trains, sirens, and rain drops. She kept saying, "They don't understand," and, "I'm bad." Janine then indicated that she wanted to go to bed and did so without further ado as long as her counselor stayed with her. She woke up the next day apparently feeling pretty well, although she was concerned that the director would tell her family what she had done. The next day the director called the hospital and conferred with Janine's caseworker. The caseworker agreed with a policy of firm, gentle control and support rather than exploration during such episodes as a basis for handling Janine, without depriving her of the opportunity to ventilate feelings. Janine settled down after this and did not repeat this behavior for the remainder of the period.

Depressive reaction associated with departure. Leave-taking at any camp is accompanied by a rise in tension; tears among girls at these times are not unusual. With deeply disturbed children, however, reactions are likely to be even more extreme. Counselors have to be able to accept without panic or counter-hostility the angry and contradictory behavior that is exhibited. The last morning of camp, for example, Andrea began by helping to make other beds, as well as her own at the counselor's request. Later, however, she refused to carry out her clean-up assignment, which was to sweep the room, and demanded that the counselor do this. She then asked for help with her packing. The counselor responded to this but when she had some difficulty with the lock on Andrea's trunk, this precipitated one of the child's loudest outbursts. She swore at the counselor, saying her mother had had no difficulty with the trunk, and that the counselor was no good. She was very close to tears at this point and left the room. Later in the morning when the campers were let off at the agency in town, the counselor saw her

again. With her mother standing nearby, she embraced the counselor and, as she had done the previous evening, said, "Half of me wants to stay and half of me wants to go."

Janine's feelings of rage at being abandoned began to erupt again as the time for departure approached. On the last day she became openly hostile toward her cabin counselor with whom she had established a good relationship. She would ignore remarks addressed to her in an attempt to hurt the counselor's feelings. She threatened to call the counselor names when it was time to leave camp. At the same time her emotional withdrawal became progressively greater. By evening, she was quite depressed and began to cry, got out of bed and asked for the director. She said she did not want to go home where she would be pulled from all sides and where only her social worker would understand her. Nevertheless, she fell into a sound sleep when the counselor sat with her. She delayed her packing the next morning but managed to control herself until she reached the city. Here, however, she broke down and began to sob. She did not respond to the counselor's questions and continued to cry as she entered the car that was to take her home. Shortly afterwards, she wrote to two counselors saying she had been so happy at camp that she wanted to come back as a junior counselor.

CONCLUSION

Not all disturbed children can be helped by a summer camping experience, even when the camp in question is operated specifically for the purpose of serving children with emotional problems. No matter how well a camp is staffed and organized from a therapeutic standpoint, many youngsters with severe ego-defects may find the demands of camp life intolerable. If the anxiety produced by the experience is too great, it will prevent them from developing any sustained relationships with staff, thereby nullifying the beneficial effects of the program. Furthermore, the amount of individual attention that they require may be so great it will disrupt the operation of the camp and seriously interfere with the activities of fellow campers.

On the other hand, as our findings indicate, if enough caution is exercised in the choice of the children and careful thought is given to their management it is possible, contrary to what has been a commonly held opinion, to integrate even quite seriously disturbed children into selected camping programs. The conditions which we regard as essential to accomplish this task are summarized below:

A. *Adequate preparation*
Since the initial reaction of deeply disturbed children to being separated from a familiar environment is likely to be so severe, it is important to take measures to reduce its intensity. With the girls we have described it was felt that their previous association in a group and the presence in camp of their leader contributed substantially to their ability to tolerate the camp experience. Where these conditions cannot be duplicated, other forms of preparation must be improvised for facilitating the transition from home to camp. These might include preseason camp visits for the child, a chance to meet his counselor and other personnel, an opportunity to ventilate his anxieties to his worker or therapist, and the presence of a familiar figure on the trip to camp and the period immediately following arrival.

B. *Heterogeneity in camp population*

There was a considerable range in the emotional status of the children at our camp. Approximately one-half were free from any serious emotional disturbance. The remainder had emotional problems of various types, but these were less incapacitating than the severe ego disorders of the girls we studied. The nucleus of stable campers was regarded as a distinct asset. Without such children, programming would have been extremely difficult, and demands on counselors would have been correspondingly greater. By their capacity for participation, they served as models for identification for other campers and provided counselors with gratifications which made it easier for them to tolerate the anxieties and frustrations engendered by the more disturbed individuals. However, had there not also been moderately disturbed campers present, the psychological gulf between the normal and seriously disturbed children might have been too great to bridge. The fact that the latter were able to observe that other campers also had difficulties reduced their sense of alienation.

C. *Flexibility in programming*

Because of the need severely disturbed children have for protective withdrawal, they must be allowed to determine the extent to which they will participate in the camp program. They should be encouraged to engage in camp activities, but demands on them should be kept at a minimum. Materials should be available with which they can work or play individually when they are unable to remain in group activities. Regulations at our camp permitted these youngsters to roam about the grounds but within prescribed boundaries. In this connection, of course, a proportionately large staff was a vital necessity so that when one of these girls wandered off, a counselor was on hand to keep her in view, accompany, or work with her. One source of support for these girls may have been in the basic organization of camp activities. During both summers, but particularly during the second, cabin units were not emphasized. Campers were not required to remain with their own cabin-mates for activities. While such a requirement might have made for superficial cohesion, it would have forced members into a consistently close relationship for which they were not ready and would have placed an overwhelming burden on their cabin counselor. If confronted with a persistent demand for cooperative performance as a unit, they might have become upset over their inadequacies in this regard. Instead, although encouraged to come together for some activities, they were each free to move in and out of groups at play as they wished, without being pressured to remain with each other. This kept their responsibility for one another down to a reasonable minimum. It also enabled staff members to share substantially with this group's cabin counselor in the major tasks involved in working with these girls.

D. *Unrestricted opportunity for personal contact with staff members*

Because of their fear of peer relationships and their feelings of isolation, children with such limited resources

make heavy demands on staff members. They should be permitted to seek out counselors individually for emotional support. The staff must be prepared to accept a high degree of "adult-directed" activity and recognize that these children cannot be pressed into more extensive peer contacts until these can be tolerated emotionally. At the same time, staff members, as they respond to the needs of these children for individual attention, should encourage them to reestablish contact with other campers so that relationships do not become centered exclusively on the exploration of problems on a one-to-one basis. With the girls we have described, to have done otherwise would have played into their pathological tendencies and isolated them further from the central activities of the camp. Our counselors had to be alert to opportunities of all types in bringing these girls individually back into relationships with other youngsters. For example, the discussion group which three of them joined originated in an interview between the director and Janine. As Janine recited her problems, the director pointed out that some of these were shared by other campers who were going through a similar stage of development. She asked Janine whether she would be interested in a discussion group where she and the others could talk over their problems together, and Janine responded to this eagerly. The positive results of this have been described.

E. *Professionally trained personnel*

It would not be feasible to admit children with such severe ego defects to an overnight camp unless a fairly large proportion of the staff was experienced in working with emotionally disturbed children. Our own staff included a number of trained social workers with experience of this kind. At that, it took all the understanding, patience, and skill they could command, and at times their own anxiety was all they could tolerate. Among the staff members who returned the second summer, it was the universal feeling that things were easier the second time around. Part of this was because of the improvement in the girls, but there was also the very important advantage of a previous summer's experience, which points up the value of specific camp experience as well as the more general social work background. In addition to having trained personnel on the camp staff, it is essential that psychiatric consultation be available. This is not only vital to the welfare and safety of the children, but also provides necessary reassurance for the staff.

It is important to reiterate that a camp experience should not be regarded as a cure for underlying pathological deviation. If carefully designed, however, it may provide youngsters who have severe ego impairment with the kinds of concrete experiences that will enable them to better manage their impulses and to react with less discomfort and confusion to the requirements of living with others. This seems to us to be especially important in the light of the scarcity of community resources available to such children. Many agencies confronted with seriously disturbed children could consider camping as one way of helping them. They will undoubtedly need to improvise in terms of their own situation, but they should be encouraged by our results to explore this possibility.

JANE BEASLEY RAPH, Ed.D.

Description of a workshop project in mental health

INTRODUCTION

A guidance worker asks, "Have I perhaps been counseling with platitudes and oversimplification?" One teacher questions, "I wonder why our culture doesn't allow an interplay between teacher and pupil for genuine expression of affection?" Another inquires, "Why do I get angry at colleagues who plan an easier program for themselves than I do?" These comments indicate some of the concerns of teachers in a concluding discussion of a course in mental health for educators. The statements also reflect a shift many of the class members had made. At the outset of the course, some of them had confined their attention chiefly to problems in classroom management and student achievement. During the closing sessions, more of them were focusing on the psychological correlates of behavior, their own as well as that of their pupils.

This workshop project provided an intensive course in mental health for two groups of teachers, one in the fall of 1958, and one for a second group of teachers in the fall of 1959. The project led to many new perspectives in relationships, not only among the class members themselves, but also among the sponsors who had first envisioned the two courses and who gave the undertaking their care and attention throughout the months of preliminary planning, implementation, and later evaluation.

A description of this project, sponsored jointly by the education and scholarship committees of the Morris County (New Jersey) Mental Health Association and the School of Education of Rutgers University, is presented here in the hope that such information will prove useful to other groups interested in similar undertakings.

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PRELIMINARY PLANNING

Selection of participants

The decision of the scholarship committee to make the courses available to school personnel was thought to have dual benefits. In the first place, the orientation of a key professional group such as this to new development and resources in mental health held promise for its becoming better informed and better able to contribute to the community's understanding and acceptance of responsibility for mental health problems. Secondly, it was considered that an educational group would have unique opportunities to draw upon mental health concepts in its direct contacts with large numbers of children and youth in the schools and as a consequence of a course such as this, would be more likely to foster healthy personality development in their pupils.

The members of the 1958 class were selected by their superintendent or principal and sent as a delegation from their school system. The members of the 1959 class applied voluntarily and were selected in such a way as to obtain countywide geographical representation and a membership representative of the various specializations within education. These included nursery school, kindergarten, elementary and secondary teachers of private and public schools, nurses, administrators and guidance counselors.

Although it is universally recognized that educators have a strategic role in the development of good mental health in their students, teacher preparation for this role is a fairly new function in the training institutions. Teachers who received their training prior to the early 1950's often lack any substantial work in psychology. Teachers who have been graduated more recently are faced with many unknowns in their day-to-day dealings, even though they have had appropriate academic courses. A number of writers have called attention to the critical importance of in-service training in this area whether it be to provide a practical supplement to undergraduate work in mental hygiene, or, as is frequently the case, to furnish teachers with new insights into the emotional development of their pupils. Kanzer (1) says, "The introduction and development of psychological insights among teachers is one of the most important problems of prophylactic psychiatry." Stouffer (2) also calls attention to this point of view when he states, "There must be continued instruction of the teacher in the dynamics of child behavior. New knowledge must continually be a part of the teacher's understanding and approach to the child." Bernard (3) feels that "Many of the teachers who have the readiness for and the capacity to merge mental health concepts, as taught by clinicians, into their own educational approach are often able to enhance the effectiveness of their teaching through access to in-service opportunities, and these should by all means be extended. Stevenson (4) regards teachers as being in a position to "buffer some of the adverse influences that bear upon the child. They are in a position to provide a good atmosphere within the school that can counterbalance the reverse at home and in the neighborhood. The least that one can expect of the school is that it should not hurt the child further, and to this end that it should take into account that children differ and need different kinds of help from school."

Plan of the workshop

Once the committee had designated the educational group as the appropriate recipient of the workshop project. it then

called upon the School of Education of Rutgers University of New Jersey for assistance in the planning, organization, and instructional aspects.[1]

It was decided to offer the courses on a graduate credit basis for eight weekly double sessions, each an hour and forty minutes in length, with an hour between the sessions for dinner served on the premises.

A number of outstanding professional leaders engaged in some phase of mental health work were to talk during the afternoon sessions of the classes and act as discussion leaders. These persons included two psychiatrists, two psychologists, a school social worker, a school counselor, a former school administrator, and a prominent professional lecturer in family relations. The evening meetings were to follow the theme of the afternoon ones with a topical presentation by the instructor and additional class discussion. At one meeting during the first course a group of parents was also to present its views on ways parents might assist teachers in understanding children. At both courses, the sponsors were to talk briefly on activities, publications, and resources of the county, state, and national mental health associations.

Topics of the sessions were to include the following: (1) Meanings of mental health and its importance in the life of teachers and students; (2) Personal and cultural bases of personality development; (3) Identifying symptoms of emotional health and ill health in children; (4) The relationship of anxiety, hostility, and authority problems to a child's development; (5) Understanding and dealing with behavior and learning difficulties in children; (6) The limitations and potentials of the teacher's role in assisting healthy emotional growth in children; and (7) School and community resources for improving mental health in children.

Costs of the workshop

The costs of the workshop project were originally planned to be carried in their entirety by the Morris County Mental Health Association. However, as an outcome of the joint planning which evolved between the committee and the school systems in the county, the association financed the tuition costs of the students and the honorarium paid the speakers. Registration fees and books were paid for by the local school systems in some instances and by the students themselves in other instances. The university paid the salary and travel expenses of the instructor.

Evaluation of the workshop

The obstacles to evaluation of mental health programs are familiar to anyone concerned with research in this area. Nevertheless, it was decided to try to obtain two measures of change: (1) Analysis of subjective judgments made by the class members themselves in a weekly log or final summary paper relative to new knowledge and understandings gained during the course; and (2) Comparison of pre- and post-test scores of the two class groups (1958 and 1959) on expressed attitudes toward children as measured by the Minnesota Teacher Attitude Inventory. The second course also used a control group made up of teachers in the county who were not enrolled in the course but who took the tests at the same time as the course participants.

[1] Dr. Robert Poppendieck, then director of administrative services in the School of Education at Rutgers, and now specialist in teacher education for the U. S. Office of Health, Education, and Welfare, was largely responsible for this stage of the planning.

THE PROCESS

As is often the case in a pilot endeavor, the ending would make a good beginning. Since the courses were exploratory in nature, a clarification of purposes and process occurred throughout which could well form the nucleus of future workshops. The instructor trimmed some of her sails of aspiration as did the participants. The class members progressed from discomfort at the lack of specific assignments and tests, through a period of uneasy trust in freedom, to achievement of some very meaningful individual analyses of particular problems in their lives or in their teaching. A backward glance in some detail may serve to highlight the learnings from the standpoint of both the instructor and the students.

The instructor

The instructor's previous experience had consisted of elementary classroom teaching, clinical work with children and parents, and the teaching of developmental psychology courses to teachers. She saw in this project some unique opportunities for teachers to learn about themselves as well as about their students, and to increase their understandings of behavior on an emotional as well as an intellectual level. Achievement of such goals required her, then, to consider both course content and instructional methods.

In reference to the content of a course in mental health, it appears that inevitably there is some overlapping of insights and understandings common to the subject matter contained in psychology and the problems dealt with in psychotherapy. For a classroom teacher to understand that a child's destructive acts may be caused by negative feelings about himself or others instead of being merely "bad behavior" is an important first step in being helpful to a child. If the teacher has sufficient background to understand some of the theoretical formulations regarding the origins of anxiety, hostility, guilt, and the like, she may be even more effective in supplying some of the child's needs or in recognizing his incapacity for accepting what he most needs. To the extent that the teacher has become aware of her own negative feelings and defenses, she has a special bridge for understanding the disturbed child. And the deeper the teacher's understanding of the origins of her own feelings, of course, the more free she is to see the child's situation clearly with a minimum of distortion caused by her own problems. Practically, then, the content of these courses was viewed in two dimensions: an intellectual extension of information about child behavior, and an emotional extension of understanding in instances where students were able to grasp some of the personal meaning of the content.

In reference to the instructional role, the courses also seemed to require a combination of therapeutic and educational understandings although the primary function was seen as instructional. Bernard (3) describes the interconnection in this way: "The clinician-instructor (of in-service teacher education groups in mental health) must steer a middle course between the pitfalls of trying to bring about psychodynamic understanding in an emotional vacuum, since this cannot lead to understanding, or letting the interpersonal situation slide into an inappropriate, uncontrolled, quasi-therapeutic morass."

This middle road was not difficult for the instructor to follow when it involved presenting concepts *about* mental health and psychodynamics, or when it called for a clarification and elaboration of the presentations made by the speakers on the basis

of comments and questions raised by the students. Its direction was less clear when class members expressed attitudes which appeared to reflect unconscious resistance to threatening material. To avoid the implications of such issues as the presence of aggressive impulses in nearly everyone, the likelihood of both love and hate characterizing a close relationship, and the benefits of recognition rather than denial of feelings, the class members often drew upon what Chisholm (5) called the—"binding certainties imposed in childhood" governing respect for authority, the rights of the group, and the need for firm discipline. In these instances, the instructor usually accepted and restated the expressed reactions as being one person's point of view at that time, often not interpreting further or raising questions, except as class members did. This posed the problem of whether some of the psychodynamic understanding which was a goal of the two courses was being lost in the retreat to a more didactic emphasis. At the conclusion of the courses, it appeared to the instructor that such procedures had led to some emotional insights on the part of some class members but probably to a strengthening of intellectual defenses on the part of others. And perhaps this is par for such a course, as it probably is for any human experience.

Certain barriers to achievement of an understanding of mental health concepts, other than content and method, persisted throughout the courses, and were seen more clearly at the conclusion than when the courses were in progress:

1. The tendency of teachers to seek a solution to a child's problem before searching for an understanding of it;
2. Their tendency to focus only on a child's disruptive behavior and ways to modify it rather than examining their own reactions and feelings toward the child;
3. Their tendency to veer away from the unpleasant realities of problems in their own life and the lives of others and to adhere to an ideal of what life *should* be rather than what it is;
4. Their tendency to expect a great deal of themselves as teachers, to be all things to all children, to have a profound and even "curative" effect on every child; and
5. Their tendency to want to fix everything up so it will be all right rather than facing the insecurities within themselves, attempting to understand and handle them, and then helping children to do the same.

The students

The participants in the courses described in their evaluations some of their reactions and learnings and in individual instances attempted to account for them. The following material, with their permission, was drawn from their final evaluation sessions, one of which was recorded, from a reunion of one class five months after its last session, and from their final summary papers.

Both groups commented favorably on the learning climate of the courses. They appeared to be particularly appreciative of such an opportunity being *given* them, not only that the costs were taken care of for them in most instances, but that the topics, speakers, assignments, and time schedule had been worked out with special reference to their interests, needs, and responsibilities. Professional attention might profitably be directed to giving teachers more assistance and encouragement of this kind.

While the two groups suggested having

fewer speakers at forthcoming workshops or making use of panel presentations by several speakers at the same meeting, the issues raised by the speakers formed much of the substance of the courses. Those mentioned most frequently were as follows: (1) Confidentiality of psychological reports; (2) Long-term nature of behavioral change; (3) Limits of treatment results; (4) Preliminary considerations in accepting a child for psychotherapy; (5) Dangers of labeling a child adversely; (6) Usefulness of anecdotal descriptions when a child is referred for diagnosis or therapy; (7) Problems in communication among professional workers about a child; (8) Relevancy of anxiety and hostility to the educational process; (9) Importance of early identification of emotional problems; and (10) Availability of assistance for teachers in dealing with disturbed children and for the children themselves.

An objective evaluation

The Minnesota Teacher Attitude Inventory was administered to the class participants in each of the two courses, before and after being enrolled in the course. A control group was used in the second course made up of teachers in the same county school system selected individually by each course member as being similar to himself in attitudes toward children. The control group took the tests at approximately the same time as did those enrolled in the course.

The MTAI is designed, according to its authors, to measure those expressed atti-

A statistical comparison of pre- and post-test scores made by three teacher groups on the Minnesota Teacher Attitude Inventory in conjunction with a course in mental health

	N	MEAN	SD	S–D	t
I. *1958 Class Members*					
A. Scores BEFORE Taking Course	25	33.40	37.20		
B. Scores AFTER Taking Course	25	45.10	31.00	5.13	2.33*
II. *1959 Class Members*					
A. Scores BEFORE Taking Course	26	47.50	21.36		
B. Scores AFTER Taking Course	26	62.39	19.20	4.5	3.14**
III. *1959 Control Group*		44.36	27.51		
A. FIRST Scores	19	43.26	30.59		
B. SECOND Scores	19			.85	1.67

* Significant at the .05 level of confidence.
** Significant at the .01 level of confidence.

tudes of teachers toward school work and children which are said to be indicative of how well a teacher gets along with pupils in interpersonal relations and, indirectly, how well satisfied the teacher is with teaching as a vocation. A validity coefficient on Form A of the test of .59 was obtained when test results were correlated with T-score averages of three outside criteria of teacher-pupil rapport as evaluated by principals, pupils, and experts. A reliability coefficient using the split-half Spearman-Brown was .93. These figures are reported in the test manual.

For use in the workshop project then, a null hypothesis was assumed, namely, that there would be no change in the attitudes of class members toward children and teaching as measured by the MTAI before and after their enrollment in a course in mental health.

RESULTS

On the basis of application of a t-test of significance to the difference between pre- and post-test scores of class members, the null hypothesis for both groups in the workshop project can be rejected. In other words, a change in scores as great as occurred between the pre- and post-tests of the class members in both the 1958 and the 1959 courses would be likely to occur, by chance, only five times in a hundred or less. Such changes in scores, to the extent that these scores can be assumed to be an outgrowth of reading, discussion, lectures, and instruction occurring within the framework of the workshop project, can be regarded as one type of evidence that such an experience was valuable to teachers in changing their attitudes in a positive direction toward children and teaching.

The fact that the control group showed no difference between its initial and final test scores lends support to the above conclusions. However, it must be borne in mind that such expressed teacher-pupil attitudes as measured by the tests are probably simply indicators of the teacher's attitudes and may not reflect actual changes in behavior within the classroom.

CONCLUSION

This report has described the preliminary planning, procedures, and evaluation of a workshop project in mental health for teachers sponsored jointly by the education and scholarship committees of the Morris County (New Jersey) Mental Health Association and the School of Education of Rutgers University. Its outcomes might be summarized graphically by a statement made by one of the participants:

"I've learned to be more realistic about children, that they are different, each one, and that there is no pat solution, no easy answer that can be applied in all cases. But more than that, I've found for the first time in a college course that *I* count, too. Either I didn't even think about myself, or I just blamed myself when things went wrong, instead of giving myself some of the credit and some of the understanding that I think is so important for children."

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The legal profession as a member of the psychiatric team

Traditionally, the psychiatric team has consisted of psychiatrists, social workers, nurses, and psychologists. However, it is another group, the legal profession, which, often has the initial contact with a mentally ill person or his family and thus has much to contribute in the treatment of mental illness. Members of the legal profession and its ancillary branches can make a significant contribution to the care of the mentally ill, provided their approach to the proposed patient or his family is therapeutically oriented. Process in therapy begins prior to actual hospitalization of the patient. The person or persons who have the first contact with the patient or his family establish the emotional climate and set the stage for treatment. In many instances, the first professional person to whom the family turns when a relative becomes mentally ill is a member of the legal profession or of the enforcement agencies, such as the police, sheriff, etc. The importance of this initial contact has been long overlooked by the legal profession and by other professions directly involved in the care of the mentally ill.

Most frequently the legal profession is consulted when the family is considering a commitment to a state hospital. Statistics are not readily available to indicate the number of patients hospitalized as a result of a legal commitment, but Kittrie (1) states that more than a quarter of a million new patients are admitted each year through legal channels. Therefore, it becomes obvious that all professions involved in the care of the mentally ill should be

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vitally interested in the medical-legal aspects of commitment.

Commitment laws vary from state to state, and the simplicity or complexity of the laws range from a single half-page document to a lengthy treatise, thus making the medical-legal picture more complicated. In an effort to clarify commitment procedures and to achieve some unification, a Draft Act was written under the auspices of the Federal Security Agency in 1949 (2).

In the Draft Act an attempt was made to focus on the specific questions which needed to be answered before determining commitment and to eliminate from legal consideration those matters which are degrading, harmful, or not pertinent to the person's state of mental health. For instance, the consideration of the financial circumstances is unnecessary at the time of commitment. There should not be an equating of incompetence and the need for mental hospital care. The use of a lay jury is undesirable and, often, insistence that the patient be present during the hearing is detrimental to him.

Recently at the Ninth Mental Hospital Institute (3), a section was devoted to the discussion of commitment laws, and there was general agreement upon the following points:

All parties involved should be primarily concerned with the patient and the trauma he suffers during the procedure and, at the same time be concerned with protecting his legal rights. Publicity, police custody, and detention in jail should be avoided. The stigma should be removed from commitment, and involuntary hospitalization should not be restricted to those considered dangerous to themselves or someone else but should be available to those in need of treatment who, because of their illness, lack sufficient insight to make application. Voluntary admission is always to be preferred since the patient's involvement in the process helps him to accept more readily and to participate more fully in therapy. Lastly, procedures based upon the criminal law should be abandoned.

Slowly, state legislatures are abandoning archaic procedures and adopting new, more humane commitment laws. Utah was one of the first states to make legislative changes consistent with the Draft Act of the Federal Security Agency. A committee under the able leadership of Dr. C. H. Hardin Branch, Judge William S. Dunford, and Judge Joseph G. Jeppson [1] proposed to the legislature a commitment law based on the model draft act. A law which incorporated this model act was passed in May, 1951. Since then, commitment hearings have become a part of the treatment process and less traumatic to patients and their families.

Specific points from the Utah State Code (4) illustrate the incorporation within the law of a therapeutic and humane attitude towards the proposed patient:

> "The State Insane Asylum now established and located at Provo, in the County of Utah, State of Utah, shall be known as the Utah State Hospital. . . ."
>
> "Upon receipt of an application, the court shall give notice thereof to the proposed patient, to his legal guardian, if any, and to his spouse, parents, and nearest known other relative or friend. If, however, the court has reason to believe that notice would be likely to be injurious to the proposed patient, notice to him may be omitted. . . ."
> "The patient, applicant, and all other persons to whom notice is required are given an opportunity to appear at the hearing. . . . The hearing shall be conducted in as informal a manner as may be considered (consistent) with orderly procedure and in a physical setting not likely to have

[1] Dr. C. H. Hardin Branch, head and professor, Department of Psychiatry, College of Medicine, University of Utah; William S. Dunford, Judge, Fourth District Court, state of Utah, deceased; Joseph G. Jeppson, Judge, Third District Court, state of Utah.

a harmful effect on the mental health of the proposed patient. . . ."

"While awaiting the judicial hearing, prior to his removal to the Utah State Hospital, he may be detained in a hospital, foster home, nursing home, etc., or any place which is under the jurisdiction of the Department of Public Welfare. He shall not, except because of, and during an extreme emergency, be detained in a non-medical facility used for the detention of individuals charged with or convicted of penal offenses. . . ."

"A committed patient shall be entitled to communicate by sealed mail or otherwise with persons, including official agencies, inside or outside the hospital, to receive visitors and to exercise all civil rights, including the right to dispose of property, execute instruments, make purchases, enter contractual relationships and vote, unless he has been adjudicated incompetent and has not been restored to legal capacity."

Granted that no law is better than the persons administering it, the Utah law does provide certain conditions and privileges which are bound to be beneficial to a patient. As a result of this structure, a patient maintains a sense of responsibility for himself and views hospitalization as a step towards regaining his health.

There are four methods by which a patient may be admitted to the Utah State Hospital and for purposes of clarification, a brief review of these provisions follows:

First, the patient may be admitted on a voluntary basis, which is desirable under most circumstances. The patient may, if sixteen years of age or older, sign himself into the hospital. If the patient is under age sixteen, his parents or guardian may sign the admission form. This means the patient is free to leave the institution at any time upon written request and should this occur prior to the time the superintendent deems it desirable, he (the superintendent) has 48 hours in which to act on the request. If he believes the patient is a danger to himself or someone else, he can file a petition with the local district court asking for a hearing on the case. While awaiting the hearing, the superintendent has the authority to detain the patient in the hospital.

Secondly, a patient may be admitted on a voluntary-involuntary basis, more correctly known as the standard nonjudicial method. In this instance, a relative or friend makes the application on behalf of the patient, since the patient is unable to carry out the procedure because of his illness; two doctors designated as examiners by the Welfare Commission examine him and certify his need for hospitalization. This procedure is helpful in handling a patient who is moderately resistent to hospitalization but who will accept such planning once others have taken the necessary steps for admission. Similar to a voluntary admission, a patient can request release from the hospital and must be granted his written request unless the superintendent obtains legal authority to detain him.

An emergency procedure is used only in extreme situations and is the third method. A health officer, or police officer facing an emergency may place the patient in the hospital immediately either with or without the endorsement of a judge. This method is the least acceptable or desirable and is used rarely and then only in the case of a violent or dangerous patient. This procedure must be restricted to emergencies since there is no medical examination of a condition which warrants medical concern.

The fourth and last method is the involuntary or commitment procedure. This process may be initiated by a friend or relative who goes to the county clerk's office in the area in which the patient resides to give information to the county attorney substantiating the need for hospitalization. If the patient has seen a physician recently, a medical certificate is included in the application. However, if the patient

refuses to submit to a medical examination, a paragraph is endorsed stating his unwillingness to cooperate. When he receives the information, the county attorney draws up the document and submits it to the judge for his signature. After reviewing the material, the judge issues an order designating two certified physicians to examine the patient. If, in the opinion of the family or friend, the patient is likely to do harm to himself or to another while awaiting the examination, the judge can issue an order detaining the patient in a hospital for observation prior to the date set for the hearing. The patient is brought to a psychiatric unit in a general hospital, and a complete evaluation is done. This process involves interviewing the person who signed the affidavit to further clarify the information given to the county attorney. The patient is seen by the two designated examiners, and the result of this examination is submitted on an official form to the court. If, following the psychiatric examination, there is no need to hospitalize the patient, the judge can be so notified, and the case is dismissed immediately without a hearing. If, however, the case needs to come before the judge for commitment to the state hospital, a date for the hearing is then set through the county clerk's office. The law requires a five day legal notice prior to the hearing. Since the law provides that such hearings shall be held in a physical setting not considered harmful to the patient, they are always held at the General Hospital in Salt Lake County. This setting is less disturbing to the patient than the court room which tends to associate mental illness with criminality. Only those immediately involved, such as medical and social work personnel of the hospital, legal counsel, members of the family and close friends are permitted to to be present at the hearing. The emphasis throughout the commitment process is on the medical problem rather than its legal connotation. Since the inception of the 1951 commitment law, lawyers involved in commitments have become adept in helping the patient accept that which is best for his mental health. If desirable, the patient attends the hearing, but he is not compelled to do so. However, most patients are urged to appear so they may feel they have participated in the decision.

Because of the nature of the Utah commitment law, and because the intent of the law is to facilitate treatment, the judge is patient-focused and often helps the patient to recognize hospitalization as a necessary medical rather than punitive procedure. Excerpts from case records may serve to illustrate the therapeutic atmosphere of the court.

Mrs. S. was a thirty-five-year-old woman who was signed into the hospital on application by her husband. She was the mother of three children and had been acutely disturbed for the past three months. She had difficulty in caring for her children and her home, because she was becoming more preoccupied with her delusional thinking. The physicians examined her and diagnosed her illness as a schizophrenic reaction, paranoid type. In their report, which the judge had read, they recommended hospitalization at the Utah State Hospital for an indefinite period of time.

At the commitment hearing, the judge told the patient, "The purpose of this hearing is to determine if you need hospitalization." The patient's response was that she did not think she needed it. The judge then asked, "Don't you think people at the hospital can help you?" With reluctance, the patient indicated that they might be able to do so. The judge pointed out, "Very often

people who are mentally ill don't realize it. From the evidence presented to the court I would have to commit you unless you have some doctors to say you are not ill." The patient said she had no such evidence. "If you were a judge and two doctors said you were ill, while you said you weren't, how would you decide? Do you see the difference in the weight of evidence?" The patient indicated she could, and the judge continued, "I can continue this matter a week for you to get a doctor to testify in your behalf, or you can acquiesce and immediately start treatment. If I were in your situation I believe I'd accept the medical viewpoint. What do you wish to do—decide today or have a week's delay?" The patient stated she would accept whatever he thought best. "Based on the evidence given by the doctors, it is the judgment of the court that you are mentally ill and should be committed to the state hospital. Good luck to you." The hearing was concluded.

Mr. B. was a twenty-nine-year-old single male who had been chronically disturbed but recently had become unmanageable at home because he was acting out his delusional ideas. His parents had found it increasingly difficult to get him to eat properly or to have enough sleep. The doctors diagnosed him as a chronic schizophrenic and recommended hospitalization.

At the hearing the judge instructed the patient that it was necessary to determine whether or not he needed hospital treatment. The young man doubted that he needed it and the judge stated, "The doctors here think that if you took some treatment in a hospital you'd get well and again be able to enjoy things." The patient expressed his interest in clerical work and added that he had enjoyed his previous employment. The judge responded to the patient, "I believe if you had some treatment you'd be able to return to work." The patient wanted to again enjoy things and indicated an acceptance of whatever was necessary. "Then it's acceptable to you to receive hospital treatment." The patient nodded his approval, and the hearing was concluded.

These brief excerpts from the records demonstrate the attempt made by the judge to involve the patient in the decision. Most patients accept the recommendation of the court, and their response is directly related to the sincere efforts on the part of the judge to be an active participant on the psychiatric team assisting in the treatment program. Without question, the judge's judicial position has significance to the patient, and when the judge uses his position of authority in a constructive manner, he makes a unique contribution to the treatment of the mentally ill. No other member of the team carries the degree of authority represented by the judge. When used correctly, this authority can have beneficial effects on the patient.

Should the patient object to the psychiatric recommendation, he is given one week in which to gather evidence which will support his plea for dismissal of the case. He is informed that a psychiatrist or medical doctor testifying in his behalf will be the most pertinent evidence he can present. Frequently, the patient returns the following week having decided he will accept the recommendation of the physicians and the decision of the court.

At all times the final decision on commitment rests with the judge, who generally acts on the medical recommendation. If, at any point, the judge disagrees with the physicians, it is his prerogative to do so. Occasionally, he will decide to commit a patient because the individual in his opinion is a social menace. In some of these

instances, the patient is unlikely to respond to treatment, and hospitalization has questionable value as a therapeutic measure but has specific value as a protective one.

The single question before the court is whether the patient is mentally ill and is therefore in need of hospitalization. There are two reasons for involuntary commitment to the Utah State Hospital. Either the patient is mentally ill and lacks sufficient insight to make application for himself or he is a danger to himself or others. These are the only legal justifications for action. However, within these limitations the judge can exercise considerable flexibility and interpret the law broadly to benefit many patients previously denied hospital treatment.

The question of competency is not a part of the commitment hearing and rarely is raised unless the patient is diagnosed as having an organic brain syndrome, a chronic type from which he will never recover. Should it be assumed that the individual is incompetent and in need of a legal guardian, a separate hearing is held in the district court. At this hearing, the evidence and testimony must bear upon the patient's competency or lack of competency, and physicians may be called to testify as expert witnesses.

Members of the patient's family are not asked to testify under oath unless there is disagreement with the physician's recommendation or dissension among the family. If the relatives do not give formal testimony, the patient can continue to feel as though his family and friends have been loyal to him and had not taken part in an action which initially feels wrong or punitive. This course of action is particularly helpful when handling a paranoid patient who views everyone as his enemy. Hospital personnel try to prepare both the patient and his family for the medical recommendation which has been forwarded to the judge, thus reducing the amount of emotional turmoil experienced on the day of the hearing.

Borderline cases present the greatest difficulty for all professional people concerned and cause the most severe disagreements among them. The course of action for the individual who is overtly psychotic or for the one who has sustained permanent organic brain damage is clear cut, but the patient who at times is in contact with reality while at other times is grossly disturbed causes physicians, lawyers, and judges grave concern. Doctors have, by virtue of their training, knowledge which assists them in planning a medically sound treatment program, but, frequently, lawyers and judges have only a layman's understanding of these problems. During the past few years, lawyers and judges in Utah have been expressing an increasing interest in psychiatric knowledge. With the passing of time, it is becoming more the rule rather than the exception that lawyers and judges involved in commitment hearings possess a fair understanding of psychiatric diagnosis and the probable course of treatment. As their knowledge increases, it becomes easier for physicians and lawyers to agree on the best plan for the patient's mental health.

On initial examination, the Utah law may seem to many persons, especially to members of the legal profession, to be too broad. However, professional people, including members of the legal group, who have worked with the provisions of the law have found it generally to be beneficial to patients and their families. The law has not been abused, and the credit for such must be extended to the officials administering it. In 1952, a year after the Utah legislature adopted the new commitment law, Branch (5) conducted a brief survey of those most directly concerned with it to ascertain

their opinion regarding its advantages or disadvantages. Approximately 86 per cent of those responding thought the new law a significant improvement. However, there were those, mainly judges and lawyers, who had some reservations. This latter group believed the law made it too easy to commit a patient to the hospital and expressed concern that the individual's rights be disregarded. These are some of the same concerns expressed by members of the American Bar Association and reported by Kittrie in his article, "Justice for the Mentally Ill" (1). Clearly, the ideal law in final form has not been written. This situation is recognized by the American Bar Foundation which has assumed as one of its first projects the study of mental illness and the legal entanglements. Only since 1954 has the legal profession begun expressing an interest in the legal problems of the mentally ill. Enlightened physicians do not want a patient denied his civil rights, and the legal profession recognizes the need for humane, medically sound procedures. The present procedure is imperfect, but it is indisputable that cooperative action among all professional groups offers the patient the healthiest possible future.

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ROBERT L. LEON, M.D.

A participant-directed experience as a method of psychiatric teaching and consultation

This report will illustrate the learning of psychiatric concepts through the interchange of feelings, attitudes, and information in a democratic group setting. We show how, by clear and adequate communication, a group of health workers was able to move toward the solution of problems of interpersonal relationships. These problems arose out of efforts of Public Health Service personnel to meet the health needs of American Indians, but similar problems must be resolved in any health program.

Two consultants, a psychiatrist and a psychiatric social worker, met in 11 monthly sessions with a group of physicians, medical social workers, and other personnel stationed by the Public Health Service on widely scattered Indian reservations or in towns near these reservations. This group of approximately 18 members assembled with the consultants at a central location once a month for sessions which ran from 1:30 to 5:00 P.M., and 8:30 A.M. to 12 noon the following morning. Approximately one-half of the group were physicians; four were medical social workers, and there was, in addition, an anthropologist, a public health nurse, and a public health educator.

A request for consultation was initiated because of the recognized need for mental health services for Indians. Since sufficient personnel was not available to allow trained mental health workers to participate directly in a service program, a consultation program was thought to be the best beginning step.

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Psychiatric consultation and training for physicians and other health workers in isolated areas remains a great problem in this as well as other countries. Universities offer post-graduate courses usually in central locations or offer occasional lectures in outlying areas. With some exceptions, however, the teaching has been of a didactic nature.

Smith (1) *et al.,* in their program to train general practitioners in the treatment of chronic alcoholics, were able to allow for a good deal of participation by the trainee. The program of Watters and Atkinson (2) has much small group participation.

Balint (3), on the other hand, provides for a discussion of feelings on the part of the physician in a small group setting as one of the major elements of a program to train general practitioners in the use of doctor-patient relationships.

We do not believe the didactic method is the most suitable in the teaching of psychiatric and psychological concepts at the post-graduate level. Rather we believe, as does Cantor (4), that learning is a dynamic process in which the student must struggle with problems and move toward a reorganization of the self. Balint (3), whose book was published during the time the author's consultation program was in progress, states that "the acquisition of psychotherapeutic skill (among general practitioners) does not consist only of learning something new; it inevitably also entails a limited, though considerable change in the doctor's personality."

The consultants' conviction, then, that learning in the consultation process could only take place through participation by group members within a permissive relationship, in effect, gave the initial structure to the group. The consultants set the limits for their own participation. The group was free to set goals, select topics, and otherwise determine the direction and nature of the discussion. The group was not, however, free to place the consultants in an authoritarian position. A group leader was picked from among the physicians. The consultants were thus free to serve as resource people.

At the first meeting the group was told that psychiatric consultation would be available and that the group was free to determine, within limits, how to use this consultation. There seemed to be two schools of thought at the early meetings as to what was expected from consultation. Some felt the sessions could take the form of group therapy, whereas others wanted the consultant to tell them how to handle neurotic and psychotic patients. The consultant relieved considerable anxiety by discussing the difference between consultation and group therapy. He further stated that it was not his purpose or desire to solve the participant's personal problems.

The group members decided to begin the series of meetings by bringing specific problems involving patients with psychiatric or emotional disorders. Later, as participants became more comfortable, more general, less well-defined problems that the physicians were having in inter-staff relationships or physician-patient relationships were brought for discussion. In the first several sessions specific information on the handling of psychiatric patients was requested. As is often true in the beginning of a consultation process, cases of severe psychoses or severe organic brain damage were presented to test the consultant or, in the case of some group members, to prove that the consultation could be of no value. These cases were used, however, to illustrate basic human motivation even though helpful recommendations many times could not be made. Most of the group members soon dropped this sort of testing, but it

persisted with one or two members well into the sixth and seventh sessions. Those who presented these severe and difficult problems were the ones who felt the most need to "take something back" to the reservation and were the very same group members who found it extremely difficult to become emotionally involved with the group. One of the doctors who early expressed the need for much factual information later began feeling comfortable enough to present material from interviews with patients. At the end of the 12-month period, when the sessions were being evaluated by the group to determine whether or not the program was to continue, this same physician stated that he believed that the doctor's attitudes and feelings affect the treatment of his patients; it was, therefore, important and justified to give the doctor the opportunity to explore feelings and better understand himself. This physician probably presented the most dramatic example of change.

The need to understand Indian culture as different from the cultural patterns of the participants, physicians and social workers, was also present. Here the anthropologist was quite helpful in presenting the needed clarifications. Early in the sessions, much time was spent discussing the subject of cultural differences. As the doctors felt more free to understand their own feelings, and as they became more comfortable in dealing with the emotions of others, there was less talk of Indians being "different." The discussion shifted to emotions common to all people. For example, in the first meeting it was brought out that the Indian's concept of time differs from that of middle-class non-Indians. Among other things, he lives more for the moment; he is not too concerned about appointments made in the future. If he has a severe illness, such as tuberculosis, he apparently does not want to spend sufficient time in the hospital to rid himself of the disease. By the third session, the doctors had learned from the Indians themselves their feelings about tuberculosis and about many of the hospital procedures. These feelings were appropriate and understandable in terms of the disease and the situation. The attitudes expressed by the doctors then shifted. Indians were no longer looked upon as being radically different. It was evident that behavior of Indians could not be explained on the basis of simple, stereotyped, cultural differences.

The material presented for discussion during the course of the year can be grouped under three headings: (1) problems presented to the doctor or social worker by an individual patient; (2) institutional problems, that is, problems of patient-staff interaction in Indian boarding schools, in the tuberculous hospital, and in the general hospitals on the reservations, and (3) staff inter-relationships and administrative problems. As to be expected, these areas overlap somewhat.

The following are examples of patient problems which were presented: A five-year-old girl with otitis media was brought into the clinic by her mother. During examination and treatment for the otitis, the physician found the girl could not or would not talk beyond saying a few simple words. Her mother was questioned about the child's talking and immediately became anxious and excited. She gave little additional information and refused help for the speech problem in her child. She expressed much fear that the child would be taken away. The mother said that she would take care of the problem herself with the help of God. Her refusal to accept help plus her anxiety and excitement prompted the physician to request help

from the medical social worker. The social worker learned that the mother had deserted the child in infancy and had recently taken her back. It was further learned that members of the community in which the mother resided were afraid of the mother. She was described as excitable and paranoid. The social worker wanted to know how he could handle the problem and how he could gain entrance into the home.

The entire group entered into the discussion. Although there was not sufficient information from which to draw definite conclusions, the psychiatrist was able to discuss the anxiety underlying the mother's behavior. He pointed out that the rejection of help was probably a defense mechanism protecting against underlying guilt or other conflicts. The major contribution of the other group members, however, was to discuss with the social worker his own anxiety and frustration over not being able to help this mother and child. The social worker was better able to accept this discussion of his own feelings from the group than he would have been from the consultants alone. It then became apparent to the worker, as well as to the other members of the group, that the worker's anxiety had prevented the development of a tentative plan of action.

A woman in her sixties came to the clinic complaining of pain in her foot. She was hospitalized overnight for study, and diagnosis was made of peripheral vascular disease. The woman was advised that she would have to remain in the hospital for prolonged treatment, and that amputation of the foot might be necessary. The urgency of the situation was presented to the patient and her daughter who had accompanied her. The woman spoke very little English so the daughter acted as an interpreter. The woman stayed in the hospital three days and left against the physician's advice. It was subsequently learned that she had gone to a private hospital in a town near the reservation. There two amputations were performed at successively higher levels on the leg, but the stump did not heal. At the request of the physician in the private hospital, she was returned to the reservation hospital where she had first been admitted. A third amputation was performed. Good healing of the stump resulted. The physician who presented the case felt that the woman left the hospital against medical advice because she was not aware of the severity of her illness. The doctor stated that he felt inadequate because he could not get the woman to accept the necessity of remaining in the hospital for treatment. As a result of his own feelings of inadequacy and frustration, he pressed harder and harder and presented the medical picture to the woman with more and more urgency. Significantly, however, he did not allow the woman to express her feelings about being hospitalized. Entirely through chance, the anthropologist had talked with the woman's husband at his home on the reservation. The husband described the wife's illness and related the history of her medical care. The husband said that he and his wife had been satisfied with the care that she had received at the reservation hospital. Indeed, he even complimented the doctors. He told the anthropologist that this was the first time that he and his wife had ever been separated in their 40 years of marriage. When she had first entered the hospital, they were both extremely lonely, and this was the reason she returned home.

This case probably presented one of the best examples of how disturbed communication can occur in the physician-patient relationship. Through the husband we learned the patient's motivation. The doc-

tor had clearly expressed his own opinions and feelings as to why the patient acted as she did, but his inferences regarding the patient's motivation were incorrect. This case also illustrates our thesis that learning and insights best occurred when motivations and feelings of all parties concerned were understood and expressed. The doctor, because of his own anxieties, had not allowed the patient to express her feelings.

Many institutional problems were brought for discussion. One of the most meaningful, however, again related to the expression of feelings, this time on the part of the Indians who had been hospitalized.

It had been routine for the staff of the tuberculous hospital to periodically lecture to the Indians on tuberculosis. The staff would give a general discussion of the disease and discuss prophylactic and other health measures. This was usually done in the auditorium with the Indian patients in the audience and the physicians and other staff members on the stage. As a result, partly at least, of the increased interest in feelings of patients stimulated by these consultation sessions, the staff of the hospital decided to reverse the situation. The Indians were asked to go onto the stage, and the staff sat in the audience. With the help of an interpreter, these Indians then told the staff their own feelings about tuberculosis, how they felt about being in the hospital, and how they had felt when they were first told they had the disease. For example, the Indians reported that they felt insulted if the doctor was not tactful in telling them they were infectious to other members of their family. Some Indians felt the doctor was accusing them of wanting to harm other family members. This apparently was quite an emotional experience for both Indian patients and house staff. As a result, many hospital policies, rules, and regulations were changed. Patients' emotional needs were more adequately met. Following these changes, the number of patients who left the hospital against medical advice dropped sharply.

The discussion of the administrative problems centered for the most part around the physician who discussed his difficulties relating to nurses, Indian sanitarians, and other such people in the hospitals or in the field health service teams on the reservations. Some of the physicians on the reservations were young doctors who were experiencing administrative problems for the first time. Here again, when the physician could clearly express his anxieties and hostilities to the personnel working under him, he could reach some sort of solution for his problems. One situation brought for discussion was that of a physician who was unable to get his nursing staff to carry out the kind of program he wanted. The physician spent most of an afternoon discussing his own feelings and inadequacies but was able to move no further. He could not accept help and suggestions from the group nor could he convey much more than the feeling that he felt anxious and frightened. The group tended to become irritable since the doctor could obviously not resolve his own neurotic problems, and the general discussion ended rather unsatisfactorily.

DISCUSSION

The consultation program, as it progressed, represented the dynamic interaction of a number of complex variables. For the purpose of discussion, we will separate some of these variables which we feel contributed significantly to the favorable outcome. In this regard, two constellations or groups of factors seem to merit equal consideration.

The first group of factors relates to the setting, the composition of the group, the administrative support for the program,

and the common purpose and goals of the participants. The group was dedicated to the common goal of improving health services to Indians. The need for developing mental health services for Indians was recognized by staff at both service and administrative levels.[1] There was thus a high level of motivation on the part of the participants. Most of the participants had worked together at one time or another on the reservations or in the central office, but since the reservations were widely scattered, there was little opportunity for social or professional intercourse. Thus, the monthly meetings presented a welcome opportunity for the participants to get together.

The composition of the group deserves special attention. Most of the group members had volunteered for work with the Division of Indian Health, so that they were there as a result of a process of self-selection. This tended to set up a kind of homogeneous group which was further pulled together by common goals.

The second constellation of factors relates to group structure and group process. The nature of the democratic group process with participants selecting topics for discussion has already been described. The most important element of the group process was the more or less free discussion of feelings on the part of group members. When the feelings and motivations of individual members could be clearly understood, problem solving occurred. If these feelings could not be discussed in some way or another, and at times this discussion was indirect, then adequate communication failed to occur within the group and also between the doctor and his patient.

The exchange, recognition, and examination of feelings within the group takes courage on the part of group members, including the group leader. All manner of psychological defenses come into play to prevent the examination of feelings. These defenses are to be respected. They are rarely, if ever, approached directly. Rather, each group member must be allowed to keep his defenses intact until such time as he can comfortably allow others to glimpse behind them. Or, to state the matter more simply, group members were asked, but not forced, to examine their own feelings as they related to matters under discussion.

One particular aspect of the consultant's role should be emphasized. Although the consultants felt they had a contribution to make, they recognized that they did not know the nature of the problems to be met by Indian Health Service staff. This was verbalized to the group so that members understood that the consultants were also present to learn. Group members were thus given further responsibility for participating in the discussion.

CONCLUSION

We have here a tool, among many, of considerable value to the promotion of mental health and the attack on mental illness. We submit that a program, as outlined above, is useful in the training of general practitioners and other health workers. We do not feel that the main focus should be to achieve skill in psychotherapy. Rather, the focus should be on the doctor's relationship with his patient in all areas of medical practice.

SUMMARY

We have described here a psychiatric consultation program with Public Health Service personnel working with the Division of Indian Health. We show by the use of case

[1] We feel that the wholehearted support of the administrative staff was one of the crucial factors.

material how the learning of psychiatric concepts takes place through the exchange of feelings, attitudes, and information in a democratic group process. Factors believed to be responsible for the favorable outcome of the program are discussed.

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JOSEPH HIRSH

But little do men perceive what solitude is, and how far it extendeth. For a crowd is not company, and faces are but a gallery of pictures, and talk but a tinkling cymbal, where there is no love.—Francis Bacon, 1607

Suicide

Part 4

PART 4: PREDICTABILITY AND PREVENTION

There are no more precise predictors in the matter of suicide than in accidents, alcoholism, delinquency, drug addiction, or divorce. But each shares with the other suggestive signs which can serve as channel markers in the passage leading to the ultimate crisis or catastrophe. Psychiatry offers insight and clues derived from studies of the dynamics of the suicidal process in which suicidal fantasies, communications, and attempts have been the central features of evaluation. In our epidemiologically-oriented studies (1, 2, 3) further clues have been, and are being, sought not only through the enumeration of demographic characteristics of the successful suicide, the agents used, and the environment in which the act was undertaken, but in the interplay of the factors. Even at this early date additional marker buoys are beginning to make their appearance in the suicidal channel which may be of value in prognosis and prevention.

It is possible to make a few broad generalizations about the suicide before detailing certain precise characteristics about him, his environment, and the agents he employs which may be of significance in the process. The subcritical mass of sui-

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cide, to borrow a phrase from atomic physics, is to be found in a persuasively large number of cases in the confluence of at least three host factors—loss, aggression, and depression. These constitute the core of *dynamic host factors.* In the absence of the LAD syndrome (4) apparently relatively few suicides take place. Yet the conversion of the subcritical to a critical mass is often triggered by the most innocuous of events.

While all three "subcritical" factors mark the suicidal channel, depression has special importance. Even for the medically untrained person, its prime features are recognizable. They may be found in preoccupation with one's health and chronic complaints about aches and pains with no apparent reason, reduced energy output, increasing blandness of interest, or lack of interest and feeling tone. There are other clues: disturbed sleep or frank insomnia. In combination they soon express themselves in increasingly tense, nervous reactions, loss of appetite, loss of weight, and various gastrointestinal symptoms.

Often there is a general letdown in interests and drives. Pleasurable pursuits are reduced or abandoned one after another. There is often a curious mood flux. No matter how poorly they may feel, no matter how despondent, people in depression will say they feel fine. Occasionally, however, you will get a straight answer—"I feel real lousy," or "rotten," or "I cannot begin to tell you quite how I feel."

Whether precipitate or calculatedly deliberate, there is an overwhelming body of evidence to suggest that the suicide is rarely a rational being eliminating himself for thoroughly valid reasons. More often than not, he is emotionally and often physically ill.

In a series of 134 suicides recently studied in St. Louis (5), 101 were found to be suffering from one of five specific psychiatric illnesses; five were suffering from terminal medical illnesses (without concomitant psychiatric disease); three were apparently clinically well, and twenty-five were undoubtedly psychiatrically ill although specific diagnoses could not be made. Thus, 98 per cent of the total group were clinically ill, 94 per cent psychiatrically, and 4 per cent, medically. Sixty-eight per cent of those who were psychiatrically ill were found to be suffering from one of two diseases, either manic-depressive psychosis or chronic alcoholism. (In view of our earlier discussion of the significance of depression it is interesting to note in these groups that the suicidal act is rarely if ever undertaken in any but the depressive stage.)

A breakdown of selective symptoms and other historical data in 60 people in this series (those with diagnosed manic-depressive disease who later suicided) displays the prevalence which might give them some prognostic value. (See table on following page.)

In fact, this breakdown, particularly items (d) through (f), might serve as a useful check-list of prognostic host factors in non manic-depressive suicides. But there are other dynamically-important host factors. The patient's pre-suicidal pattern may include a meaningful group, including preoccupation with death and the desire to die, frequent and recurrent communication of suicidal ideas in general or specific statements of intent, and, in fact, actual attempts. These may not be accurate predictors but they may mark the suicide-prone with even greater accuracy than the accident-prone can be spotted. Part of the folklore of suicide posits that people who threaten suicide do not. The tragic fact is that they often do, and we would do well,

Item	*Per cent*
(a) Clinically well, exclusive of attacks of manic-depressive disease	69
(b) Previous episode of manic-depressive disease	46
(c) Discreteness of present attack. Duration of present attack:	
6 months or less	57
12 months or less [1]	87
(d) "Medical" symptoms: [2]	
Insomnia	88
Anorexia	82
Weight loss	80
Low energy, weakness	74
Fatigue	71
Constipation	28
(e) Psychological symptoms:	
Blue, depressed, sad	97
Diminished motor activity	77
Loss of interest	72
Diminished sexual interest and activity	61
Undertalkative	59
Low expectancy of recovery; "black" future	53
Feeling of being a burden	44
Indecisiveness	44
Feeling of worthlessness or marked guilt	40
Agitation	38
Personal untidiness	32
Difficulty in thinking and concentration	31
Delusions	27
(f) Disturbances in social behavior. Decreased social and recreational activity	77
(g) Miscellaneous items	
Age of onset, 40 and over [3]	75
Family history of manic-depressive disease	26

[1] Only 13 per cent of the cases had a duration of the present attack greater than one year. The maximum duration (one case) was four years.

[2] Other "medical" symptoms, such as headache, palpitation, dyspnea, dizzy spells, abdominal pain, and vomiting, which occur with a high frequency in manic-depressive disease, are not listed here because they are less specific in helping to differentiate this illness from other psychiatric diseases. They are, however, important in the recognition of and in the total clinical picture of manic-depressive depression.

[3] Age of onset is the age at the time of the first reported attack of manic-depressive disease.

therefore, to hear and to heed their ideas, their fantasies, their threats. In the St. Louis study (7), 68 per cent communicated suicidal ideas, and 38 per cent specifically stated that they intended to kill themselves. The corresponding figures for alcoholics were 77 per cent and 61 per cent.

Among the demographic host factors of special significance are age, sex, marital and religious status. In an earlier report it was pointed out that the suicide rate in the United States rises steadily from its low point in youth to a disturbingly high point in age groups over 75. In general, our figures for New York City over a 25-year period (1929–1954) follow this overall trend. Crocetti's (8) median of 49.7 years for successful suicides approximates ours. But he points out, interestingly enough, that the median for unsuccessful attempters was 31.7 years.

In the prediction and prevention of suicide, the age factor may have particular meaning for two groups, the young and the old. First, it must be remembered that the prime cause of death in children age 0–5 are accidents. The proportion of these which are truly accidental is overwhelmingly large. It is more than mere speculation to state that quite a number are not so accidental. While the predominant agents involved in true accidents in children are ingested toxic substances, purposive accidents like suicides rarely involve ingestions. Such acts are generally characterized by extreme violence.

According to Bender and Schilder (9), the methods used by children in their suicidal wishes and attempts involve jumping out of a window, which is the simplest way out, cutting one's self, stabbing, hanging, and even running in front of speeding automobiles. Only older children tend to ingest poisons.

If the impression that children who suicide are essentially creatures of violence is confirmed by studies presently underway, basic precautions would then have to be directed against violent forms of self-extinction rather than the more adult method of ingesting toxic substances.

Spite is an overtly expressed emotion in threatened, attempted, and successful suicides in the young. As a consequence, strong, hostile, and aggressive emotions expressed by children should be observed carefully and critically, their causes ascertained and eliminated where possible, and, if impossible, then controlled.

Depressions associated with separation from parents or loved ones is another important factor in suicidal attempts in the young. Separation may be in fact only temporary or may be complete, as in death. But if viewed as permanent or irrevocable, it may be highly traumatizing and may precipitate a suicidal attempt.

During adolescence, in particular, when young people appear to be in a constant state of flux and when there are marked shifts in mood and the rapid and sometimes violent appearance of anxiety and tension states, suicide may be attempted as the means of resolving what appear to be unresolvable problems.

The tensions of teen-agers require a good deal more than the casual dismissal by adults that they will pass. They do, sometimes taking the teen-agers with them. The categorical "firm hand" response similarly is often no more profitable. This is the time when good medical care in general and psychological care in particular are the most effective forms of sound suicide prevention.

At the other extreme of life, we find people who appear to be psychobiological organisms in repose or decline, slowing or slowed down in functions, in interests, in activities, and in relationships. One would almost expect as a sequential extension of these characteristics that when elderly people suicide, they would do so in a manner reflecting such patterns and dispositions. To be sure, some of them do, often by taking lethal quantities of hypnotic drugs, but a good many die violently.

The outlook for elderly people who attempt suicide but do not succeed generally is not very good. Reports of both British (10) and American (11) psychiatrists indicate that 12 per cent of those who attempt suicide in old age will make a second try and succeed within two years. This is, of course, much higher than repeat performances of younger people.

As we have already pointed out (12), there is a wide range in the suicide rates among the sexes. Crocetti found that among "successful suicides, 68 per cent were male and 32 per cent female; among the known attempted suicides, these proportions were exactly reversed. In other words, 68 per cent of those attempting suicide were female, and 32 per cent were (13) male." The ratios among successful suicides, and attempters will range, according to age, up to 4 or 5 males to 1 female. What conclusions, if any, can be drawn from these observations? Two, I think. First, that against the backdrop of LAD, the communication of suicidal ideas and other dynamic factors, men suicide with a frequency at least twice and often four times that of women. And second, when they *attempt* suicide, because of their intent, motive, or method, they are more likely to be more successful than women.

Finally, among the demographic and environmental host factors of importance in the suiciding process are those involving relational systems. The stronger these systems the less the likelihood that suicide will occur. Susceptibility to suicide is lowest among those who have strong family,

work, church, and community relationships. Crocetti's observations that: "Suicide was proportionally (on a rate basis) more frequent among the unmarried (single, widowed, and divorced) than among the married, . . . attempts at suicide, on the other hand, were relatively more frequent among the married" (14) are supported in the many demographic, sociologic, and psychiatric studies previously reported (15).

Among the environmental factors impinging with particular strength upon the suicidal process, the ones bearing upon the L in the LAD syndrome—loss, loneliness, and aloneness—seem to have special importance. Sociologic study after study point up the fact that there is a consistently higher incidence of suicide among people who are homeless or transient, who live in transient (non-residential) areas, or who live alone. Their loneliness and aloneness is further accentuated in the weakness or absence of relational roots other than in the family, such as occupational, community, church, or recreational activities.

Time of day, season of the year, even anniversary of death may be regarded as environmental factors of some importance in emphasizing one's aloneness and loss. A number of sociological studies point up the fact that when even homeless and transient people cease to huddle together—usually a winter phenomenon—there is an increase in the suicide rates in this group. Psychiatrists have noted the low point, in a sense the most alone point, for depressed patients is in the early morning, especially between 5 A.M. and 7 A.M. The weather phenomenon, controversial though it may be, is persuasively related to suicide. Here again, there have been consistent observations of the increase in incidence of suicide among depressed people who apparently are further depressed by a drop in barometric pressure, leaden skies, storms, and unremitting winds (16).

Finally, the "anniversary syndrome" (17) has implications for suicides. The anniversary, generally, but not always, of sad events—the broken engagement, the divorce, but especially death—is a potent suicidal trigger. The anniversary of the death of a loved one is a special Ides for depressives of all ages, male or female. Two antipodal phenomena have been generally observed in this matter. In some cases, as the anniversary date approaches, there may be no overt recognition, no mention of the fact by the person in the depression. This may be a warning sign in itself. The suicide-to-be may go about his business as usual. Then, on the anniversary—and it is almost always on the date or on the day of the week itself—self-execution! In other cases, there is a steady deepening of the depression, climaxing in suicide on the anniversary date or day.

A knowledge of the methods and means of self-extermination, of their frequency and typicity (if any), of the reasons why, and the conditions under which some people chose certain methods and others do not, may not get at the root causes of suicide but may be extremely helpful as guides in prevention. Basically, this is the reason for their inclusion in this series (18).

Suicide, as we have seen, is rarely an impulsive, highly agitated, unpremeditated act. It is generally a well-defined, deliberate act. In summation, therefore, the frequency and consistency with which the following host factors make their appearance in the suicide process suggest that even if they cannot be regarded as precise predictors they must be considered in programs of prevention and treatment:

1. The LAD syndrome is an important pre-condition of the suicide;

2. Many suicides have an antecedent history of emotional and physical illness;
3. There is an overwhelming pattern of preoccupation with death and the desire to die, frequent and recurrent communication of suicidal ideas and fantasies, specific statements of intent and repeated attempts;
4. The incidence of suicide increases precipitously with increasing age;
5. There appear to be age and sex specific patterns of suiciding against which appropriate measures may be taken;
6. Susceptibility to suicide is lowest among those who have strong family ties, church, work, and community relationships.
    a. The unmarried (single, widowed, and divorced) generally have higher suicide rates than married people.
7. Time, season, and weather conditions appear to influence suicide rates.
    a. For people in depression, the early morning hours may be critical from a suicidal point of view.
    b. A drop in barometric pressures and other weather conditions are often associated with an increased incidence of suicide; and
8. The anniversary syndrome may be a real trigger mechanism for those who are depressed and potentially suicidal.

While positive management of these factors may be helpful in programs of prevention and treatment, there are several things experience has taught that one should not do.

It is improvident to take lightly even what appears to be casual talk about suicide. The various fantasies and ideas, or more specific statements of intent, should not be considered as idle words and should be taken with the utmost seriousness. In this particular case, good prevention can be built much more effectively on the conservative notion that people with such ideas more often than not mean them and far too often implement them.

The medically unsophisticated person will do well to take a leaf from the book of the experts in their evaluation of depression and in their handling of people in profound states of despair and despondency. These are conditions which call for unusually expert skill, and it can be both a serious and a dangerous mistake for this condition to be considered lightly. Such superficial attempts as argument, cajoling, teasing, or jollying the patient is not only ineffective but, in fact, may increase his depression and make him feel the futility of his existence all the more. In Ostow's study of depression, he seriously questions the hospitalization of people in such states because "the very fact of removing him from his home and job to be hospitalized may make him sufficiently desperate to pass from suicidal fantasy to suicide itself (19)."

Miller, Fellner, and Greenfield (20) wisely suggest that when hospitalization seems indicated, it should be in that type of institution with experience in dealing with depressed patients where the personnel are sensitively geared to deal with suicidal attempts. Obviously, in such institutions, maximum security measures may be taken against suicide, but perhaps equally important is the awareness on the part of the staff that premature discharge is a *sine qua non* of prevention.

In the St. Louis series (21), 10 patients in the main diagnostic phychiatric groups killed themselves within eight months after discharge from a psychiatric hospital.

It is an unusually common experience that when depressives show sudden im-

provement, suicide may be even more of a possibility than when the depression is in full swing. Miller *et al.*, therefore urge the physician "to convey to his patient that he understands how badly the latter feels. A sense of isolation is very dangerous for the depressed person. . . . In no case should the patient leave the physician's office without being given a definite return appointment. Because of the sleeplessness and agitation usual in this condition, there is a timeless quality present and the patient should not be left for a long period to his own devises . . . if the physician [and the family] waits until the depressed patient's suicidal intentions are abundantly clear, he may have waited too long." (22)

Families of depressed, pre-suicidal patients have a most difficult role to play, particularly when they are aware of the problems and dangers implicit in the situation. The repetitive and deepening quality of the problem may be one of their greatest frustrations, for they will see that, despite their most heroic efforts to make the depressed patient feel important and loved and wanted as a participating member of the family, he may not respond. Too often and tragically, this failure in response leads to resentment, anger, and hopelessness, and families must guard against this in themselves in precisely the same way that they would hold such reactions as unworthy if the patient were suffering from a broken leg or cancer. However dismally their efforts are greeted, they must try to maintain in the depressed person the feeling of being wanted. There are no pat formulae for doing this. It is certain that it cannot be done solely by constant verbal assurances of affection and regard for the patient's status and worth. It must be done, even more importantly, by the "doing" method. Among other things, this would call for meticulous attention to problems of physical well-being, for as Miller and his associates point out ". . . certain physical illnesses are notoriously depressant in effect, pancreatic disease, i.e. chronic pancreatitis or carcinoma of the body of the pancreas, brain tumor, and toxic states in association with bromides, barbiturates and *Rauwolfia* . . ." (23). Integration or reintegration into the family constellation by having these patients participate in family councils and activities is a much stronger means of re-establishing their status and worth than talking about it. This is particularly true of elderly people. Recreation and other organized time-fillers for this group must be found. For both young and old the discovery or rediscovery of religion may be enormously important.

As a basic rule, medical help is indicated long before the clues to suicide cluster. But suicide prevention and control is a burden that cannot be borne by the medical profession alone. Suicide prevention is everyone's business, and the sooner the recognition that suicide is more than a final fact but a long process with many prominent and measurable antecedents, the greater is the likelihood that much can be done to prevent it.

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LEONARD T. MAHOLICK, M.D.

Responsibilities and functions of community mental health centers

Any community mental health center that purports to affect individual and community mental health positively has the inescapable responsibility for developing three basic programs: (1) a clinical program which would "treat the sick;" (2) a broad, community-wide program sufficient in scope to involve the community in treating its own illnesses; and (3) a research program which evaluates both the clinical and community programs and also contributes knowledge to the behavioral sciences (1). The need to relieve suffering is immediate and obvious. However, we should not forget that the sick individual does not exist in a vacuum. Many forces besides his immediate family are at work molding and influencing his personality. These include educators, physicians, clergymen, lawyers, politicians, civic and industrial leaders, the executive, legislative, and judicial bodies, and other key agencies and institutions. How to reach them and translate our specific knowledge so that it can be used constructively by these groups and how to influence them and help mobilize their forces to create the kind of society which favors good adjustment and is dedicated to human needs and values should be of vital concern to every center. The fact that these problems are so vast and complex, that our methods and techniques leave much to be desired and validated, and that our current knowledge is so limited is justification enough to devote a considerable amount of time to research.

In my presentation it is to be remem-

Dr. Maholick, who is medical director of The Bradley Center, Inc., in Columbus, Georgia, presented this report as the keynote address at the January, 1959, Topeka, Kan., Workshop on Community Mental Health Centers, sponsored by the Kansas State Board of Health, the National Institute of Mental Health, and the Community Mental Health Centers in Kansas.

bered that I am speaking from the vantage point of being in a private, nonprofit, foundation-sponsored center. Having had training, leadership responsibility, and consultative experiences in community and public health clinics, I feel I am now in a position to look a little more objectively at where I have been and what I have done. These experiences have allowed me to note some differences and make comparisons. I trust that I will be able to focus sharply enough on some problem areas that will be of value here.

When the center arrives on the community scene, it will cause and be subject to many reactions stemming from a host of sources including unrealistic treatment expectations, excessive demands for diagnostic, treatment, and testing services, difficult, chronic, unsolved problem cases that agencies are unable to cope with and are anxious to get rid of, resistance to psychiatric treatment, and personal, professional, and agency jealousies, competitiveness, and other conflicts. Therefore, how the early phase of the center's development is handled is most important, for its very life, how it functions later, and the place it evolves for itself in the community can be dependent upon it.

Some of these problems can be minimized by making it clear that the center is but a single agency designed to do a specific job, and is no panacea for all of the problems of the mentally ill (2). The setting of the agency, its auspices, and general objectives should also be defined before the doors are opened. As soon as the professional staff arrives, policies and procedures should be written out in detail, understood, and accepted by the staff and its governing board. This gives the staff a sense of security and purpose and helps them weather the pressures that will be placed on them later. Thorough, well-defined policies also enable the center to keep pressure on the community for dealing with problems not covered by them. Used this way, they can be an effective tool to prevent complacency from developing after the "clinic team" has arrived. Since the center has responsibilities for developing three basic programs, it would be well at the outset to weight them and set aside a specific amount of time for each program. This, too, gives security to the staff and helps orient the center to the community.

I CLINICAL PROGRAM

Mental and emotional illnesses are the concern and basic responsibility of the professionally trained clinician. There is no escaping the fact that the community has relegated this authority to the center. How this is translated into action, however, varies widely and is an expression of the uniqueness of each individual center. Since the center's primary reason for being is to help people (3), the first task would be to develop efficient, flexible, sound, high-quality, clinical practices, and therapeutic skills. I sometimes wonder if any staff should venture very far into other activities until these goals have been achieved.

I believe firmly that the emotionally disturbed person is an agent of emotional contagion, and when he is treated effectively, the disease is prevented from spreading. There are no good reasons why priority should not be given to those cases where prognoses are most favorable and where the length of treatment is predictably short. The aim of every center should be to treat as many cases successfully per year as possible. This enables the center to have more contacts in the community which should help many individuals achieve their maximum social therapeutic potential (4). Key individuals treated successfully at the right time can be responsible for social changes

that not only are difficult to measure but, more importantly, to match. For example, one patient and her understanding husband were essentially responsible for my remaining in Columbus when I was at my lowest ebb, ready to concede defeat, and planning to move to greener pastures. This patient, now successfully treated, carried her story far and wide. More patients came. They did the same. I stayed. The news filtered back to families, relatives, friends, physicians, and to other social groups. Anxiety about receiving psychiatric treatment was markedly reduced as a result. Interest in the field was stimulated. Another patient is in many ways responsible for the establishment of our own center. I am sure these things and many others came about because of patients, and I doubt very much if talks, lectures, or panel discussions could ever have matched what they did individually. Let's not ever forget our basic responsibility—the patient. Using these policies obviates the very real problem some centers have of getting lost in their therapeutic pink clouds, treating fewer and fewer sicker individuals, and isolating themselves from the rest of the community (5). The achievement of these clinical goals boosts staff morale and gives them a sense of accomplishment and productiveness. The board will be pleased because they can see that "something is being done." In addition, the community will eventually accord the center its due professional respect and acceptance.

Although psychotherapy has become the most frequently used therapeutic tool in clinical practice, we should not forget that it is but one of many therapeutic tools available to the patient. Neither should we get grandiose ideas about psychotherapy, for it has real limitations, both as regard application and effectiveness. These limitations, however, should not cause us to retreat from our clinical responsibilities, avoid them, or take flight into frenzied community activities.

Intake policies and procedures need to be scrutinized, defined clearly, and redefined at regularly scheduled intervals at least by the professional staff and preferably by both the staff and board (6). Do we really appreciate what the prospective patient goes through? Are we a hard-to-get-to or an easy-to-reach clinic (7)? Let us look at what frequently happens to the patient as he goes through the intake routine. A telephone call is made asking for help, which is followed by a long waiting period for an initial appointment or appointments with the psychiatric social worker. The patient then is interviewed by the psychologist and still later by the psychiatrist. Conferences are held about the patient and, finally, a disposition is made. If he fits the bill, he is honored with acceptance for treatment only to be placed on a long waiting list! How stuck are we with rigid, time-honored procedures? Can we be flexible enough to adapt them to meet patient needs more effectively and efficiently? I am afraid there also is a tendency to become complacent about long waiting periods for initial consultations and waiting lists for therapy. I doubt if we have spent much energy in improving current treatment methods or inventing new ones. How much have we explored group therapy, for example? It has all sorts of possibilities. And what of our sacred cow —the 50-minute-hour? If we could find ways and means to reduce this to an effective 30-minute therapeutic appointment, we could, at one blow, double our therapeutic resources. I also question whether our current supervision methods really serve their purposes effectively. Are there better, more realistic and efficient methods to be tried? How many members of the clinic team have the slightest notion of what it

actually costs to treat a patient in the clinic setting using present methods? I am sure there are many other pertinent, searching questions we could ask ourselves. We should not shrink from them; rather, they should stimulate us to look for and find better solutions.

We were forced to do just that at the Bradley Center. Most of our patients come from the middle-class group, can afford to pay some fee for services, and want to do so. In demanding high-quality, efficient services, they placed new pressures on us and forced us to examine our conventional procedures for intake, diagnosis, disposition, and treatment planning. While I do believe our solutions have implications for all mental health centers, I am not suggesting they could or should be tried elsewhere, nor am I making any pretense to have found "the answers," but I should like to share our experiences and results with you for whatever they are worth.

Trouble came from several sources. First, our primary source of referrals (physicians) complained of losing direct contact with the consulting physician and objected to their patients being seen initially by a non-medical person, since most of them had already made and completed preliminary diagnostic studies, saw the need for treatment, and made the referral on this basis. Second, our patients became impatient with long waiting periods and delays in arriving at a disposition, duplication, and complained, usually indirectly, of not seeing the psychiatrist first. Third, we became concerned about our own inefficiency in meeting patients' needs, rigidity, costs, and unnecessary wastage of good professional time. For three years, we experimented with some variations still based, however, on conventional methods. Finally, we decided to set up a research project to evaluate our methods. Through the use of questionnaires and ratings by both the staff and our patients, we found that many of our intake procedures actually contributed little to final diagnosis and treatment planning while they consumed excessive time and money. The results of our study, additional unfruitful clinical experiences, and considerable thought forced us, in July, 1958, to make some radical changes to streamline services. Our secretaries were trained to take calls, get pertinent information on printed forms, give appointments, and orient patients as to what to expect. The psychiatrist took sole responsibility for diagnosis, disposition, and treatment planning. Other staff members were used as consultants, and only when specifically indicated. For most patients this meant fewer visits to the center (usually one), less confusing contacts with the staff, and rapid disposition. As we have learned to coordinate our efforts, we have approached the efficiency and directness of service of the private practitioner.

Still later, research gave our clinical services a second shot-in-the-arm from an unexpected direction. Our major research focus has been in the area of conducting mental health evaluations with nonpsychiatric populations. In this work we request our subjects to fill out a Biographical Questionnaire, a Mooney Problem Check List, a Cornell Index, and an MMPI. It occurred to us to use these with our new patients. They now present us with unexcelled data which is analyzed before applicants are seen. Patient response has remained consistently enthusiastic. The initial consultation is a much more intense, pointed, and productive contact as a result of this additional modification which enables us, in one hour, to formulate a reliable diagnostic impression, appraise resistances and defenses, prescribe a form of treatment or make other dispositions on the spot, discuss fees, and assign the patient to a staff member for

psychotherapy as indicated—with ease and sureness!

The need to do something about our waiting list for therapy stimulated us to experiment with a broad group psychotherapy program. We have had as many as five different groups operating each week. Consequently, it is possible to place a new patient in one of the groups immediately if individual time is not available from a staff member. Just recently we ventured into a program of group counseling for parents of our young patients. We also have been using half-hour therapeutic sessions with excellent results.

After wrestling with these problems during the past four years, we think we have arrived at something that is practical, productive, and efficient. Our sources of referral seem to like it. Our patients like it. And the staff is satisfied, too. As a result of using these new methods and experimenting with others, we have been able to release a minimum of 12 professional man hours per week for other purposes. We are seeing more people in therapy. The waiting period for initial contact seldom goes over two weeks, and emergency time is available. We are spending over 80 per cent of our clinical time rendering individual and group psychotherapy currently. A great deal of burdensome dictation has been eliminated with a corresponding reduction in clerical work. This, along with other modifications in supervision and weekly psychotherapeutic progress reports, has enabled us to eliminate the services of a half-time typist. Although we are pleased with the results of our efforts thus far, there is still need for continuing study and evaluation.

The possibilities still are limitless, and the future is very bright. I foresee the increasing therapeutic use of the telephone and the development of two-way television contacts for both individual and group psychotherapy—both designed to bring help to people in remote areas. It is not at all inconceivable that in the not-too-distant future we will be able to give reliable "mail-order" diagnostic and treatment planning evaluations. The best is yet to come.

II COMMUNITY PROGRAMS

Many of us believe that health, and, in this specific instance, mental health, is not only the responsibility of every individual but also of the total community. Therefore, we would see the center function as but one social agent among others sharing this heavy load, yet making its own unique contributions in the following five areas:

(1) *Education*

Unfortunately, a lack of understanding and acceptance of mental and emotional problems still exists. The dissemination of sound, basic mental health information is important. However, the best way to do this and the effectiveness of our techniques still remain a secret. To what extent the center should become involved and what the hoped-for goals should be need to be defined carefully.

(2) *Supervision and Consultation*

Community agencies, key individuals, and other groups touch the life of the individual at different critical periods. Hence, they are in a position to influence and redirect him. They can be helped to do a more effective job through the use of these services. However, agencies, especially, often are prone to want direct services for their clients in preference to anything else. If the center accepted referrals from them passively, it could easily pauperize the agencies professionally by relieving them of their responsibilities. It would be most

helpful and enlightening if we had some reliable data on the net effect of such supervision and consultative services. For all we know, we might well be wasting a lot of good professional time and energy that could be better spent otherwise.

(3) *Prevention*

Beyond the early recognition and treatment of illness, not much is really known about the prevention of mental and emotional disorders. This is an area that needs vigorous study, and I will have more to say about it later.

(4) *Improvement of existing and procurement of additional facilities*

No community has adequate facilities to meet even the known psychiatric needs. Opportunities to participate in training, to coordinate services and facilities, and to catalyze action are numerous.

(5) *Improvement of the social climate which makes for "health"*

To change a society to produce responsible, free-thinking, independent, civic-minded citizens is a most worthy, but enormous, undertaking. We are still lacking the theory and techniques to guide us.

It should be clear that the opportunities to function as a social agent in the community are varied and vast, but I believe it is impossible for any one center to become active and proficient in all areas. With this temptation constantly beckoning on the one hand, and with our need to justify our existence, inability to cope with treatment demands, and long waiting lists on the other hand, it is not too difficult to understand why we might easily drift into a kaleidoscopic community program. The only program that is justifiable is one in which the center has a reasonable amount of control over its destiny. This means it will have to define its goals, establish a priority system on its activities, and critically evaluate its work periodically. The center will need time to experiment with different ideas, sound out the community, and get valuable experiences. Boards should appreciate this and be encouraging and supportive. The staff should gradually settle for a limited number of objectives instead of trying to cover the entire waterfront. With the professional talent present in the three disciplines representing medicine, social work, and psychology, a considerable amount of knowledge, technique, and experience is available to the community, but we have the job of making it useful and translating it into action.

Perhaps by highlighting some of our own activities in the Columbus community, I shall be able to focus on some of the problems we ran into, how we coped with them, and the results we obtained. When the center opened its doors in May, 1955, it found itself in the midst of a large, psychiatrically-poor community. Immediate demands were made to provide psychiatric services for the indigent. It was most difficult for the agencies to understand our policies making it clear that our facility was not to be used exclusively for treatment, nor was it to be used primarily for the indigent. Our aim was to make available competent outpatient diagnostic and treatment services to an even larger group of people representing broad socio-economic needs (emphasizing those of moderate means) and also to provide for long-range community and research programs.

Our refusal to assume sole responsibility to provide such psychiatric services made us a target for a good deal of resentment and misunderstanding. We believed that services for the indigent and low income individuals should be a responsibility of the

total community and should be tax supported. We thought that by accepting all such requests ourselves we would soon be flooded with emergency, hopeless, or difficult cases and would relieve the community agencies and groups of pressure for establishing a realistic public program for mental health services. Also, had we responded to the above clamors, we would have been forced to refuse services to a larger number of relatively self-supporting persons for whom there were no services in the entire area. Since it was necessary to refuse direct services for agency clients, we offered consultation and supervision services to their staffs to help them deal more effectively with their clients having emotional problems. We tried to avoid pauperizing the agencies by insisting indirectly they could handle more problems with some assistance. While the offer was received with apparent interest, actual consultation services were used by only one agency over a two and one-half year period. We failed in this area and decided to give it up as part of our community activity. Nevertheless, our stand did keep alive the need for additional psychiatric facilities, and later we played a vital role in helping to bring this about.

By this time we had had the opportunity to become familiar with the community, so we made an appraisal of the situation and decided to work toward the unification and coordination of the agencies (8). Previously (in 1953) Community Research Associates spent $25,000 of the community's money in a careful, well-documented study of the agencies. Their findings pointed up some serious weaknesses and deficiencies. Remedial steps were suggested, but no realistic progress had been made in three years. At this point, with the encouragement of our board, we took the initiative and held two conferences which led to the establishment of a Community Guidance Council. It is our belief that our ability to get such a group started was based largely upon our own unique situation in the community, including our lack of official connections, the flexibility of our program which permitted us to allocate large amounts of staff time to this work, and the support and influence of our board of directors. During the next 18 months, we pursued a stormy course but managed to do some excellent work. Pressure for a psychiatric clinic continued, and we suggested that rather than make vague demands for such a clinic, which had failed in the past, we conduct a systematic survey of known existing needs for psychiatric and psychological services. Such a survey was carried out over an 11-month period with the cooperation of major community agencies, and a report was prepared. The center's staff gave hundreds of hours of time in making the survey and preparing the report. Its recommendations were unanimously adopted by the council, accepted by the newly reorganized mental health association for study, and were given community-wide publicity in the form of a series of newspaper feature articles. In this way, community pressure for a clinic was mobilized and intensified. In addition, the council sponsored a seminar on emotional and social problems, adopted a common referral form for the agencies, and started a pilot study on the multi-problem family. Lastly, a project on the unification of all community planning groups was undertaken which eventually led to the establishment in April, 1958, of the Community Services Association. The aim of this association is to provide central leadership and interpretation and direction for studying, planning, and action on all the community's unmet needs. Four separate, uncoordinated planning groups were abolished. Many people participated and made this possible, but the center's staff gave

generously of its time and professional talents.

In other community activities we have participated in innumerable talks, conferences, panels, seminars, etc., but we have now relegated this function to a position of lesser import. Instead, we are concentrating our efforts on sponsoring at least one professional conference each year. In this connection, we sponsored two religio-psychiatric conferences out of which an embryonic training program in pastoral counseling has developed. In 1958 we assumed initiative in a different direction when we sponsored the first psychiatric symposium of its kind for psychiatrists, psychiatric social workers, and clinical psychologists in this region. The response was so warm and enthusiastic that we are planning to continue this as an annual event. Approximately two years ago, we called a meeting of the social workers in the community, and since then the group has been meeting on a regular monthly basis. About a year ago we opened a new area when we initiated a conference attended by all the community's mental health professional personnel to determine what we could do to help each other and the community. Then we embarked on a new venture: (1) to develop a program of interest to the group, (2) to investigate how to better coordinate our resources, and (3) to study the possibility of combining our facilities to develop on a community level a postgraduate training course for the community mental health personnel of the future. I trust I have made it clear that I would see the mental health center as a well-trained, capable psychiatric unit which has clear-cut objectives, is sensitive to individual and social needs, and possesses the flexibility and mobility to seize the opportunities the community presents it, or to create them if necessary, to accomplish its missions.

While it is all but impossible to assess the direct or indirect effect the center has had on the community, the following developments have taken place: (1) A social worker was obtained for a short period by the juvenile court; (2) The local Public Health Department opened a child guidance clinic; (3) The county school system established a guidance center; (4) A new psychiatrist came into private practice; (5) A research project on mental retardation in the county began operation; (6) A 12-bed psychiatric wing was opened at the medical center; (7) The local mental health association experienced a rebirth, and (8) Four separate, uncoordinated planning groups were abolished, and a single, centralized, planning and action unit, the Community Services Association, was established. The community has acquired a total of 14 professional people in the field, where only a short time ago, there was one. We do not pretend to claim all or even a significant amount of credit for these specific developments, but we do believe we have stimulated the community in many ways and have contributed to increased interest and a changing attitude that have made such developments possible.

III RESEARCH PROGRAM

If we are to improve current methods or devise new ones for helping the mentally and emotionally ill, it is imperative to devote some time and energy to research. But how to do it and on what are constant companions. Every center can make a contribution to breaking through these barriers by attempting to engage in at least one project that is related to either its clinical or community program.

I believe I have given you two illustrations of what we have done in Columbus in this regard with reference to the problems of our intake methods and the difficulty of eliciting community support for a

psychiatric clinic without any realistic notion of the need for it. In one instance, the results of research efforts eventually led to improved clinical services and, in the other, to a much clearer definition of the extent of mental and emotional disorders and increased pressure in the community for a new facility. Currently, we are making a critical analysis of our case load.

All of us, I am sure, are interested in prevention, but there has been no approach to the prevention of major emotional problems or in the fostering of better mental health which parallels the successes being achieved with many physical illnesses. Such an approach is urgently needed in view of the magnitude of the problem and the inadequacy of our total existing resources to cope even with critical needs. Programs for preventing mental illness may be the ultimate answer, but at this stage of our knowledge, too little is known about what causes or prevents mental illness to permit effective planning or action. An approach in keeping with our level of knowledge is one aimed at reaching and appraising the mental health of non-psychiatric populations. Economic means of appraising the mental health of large numbers of individuals will also enable us to identify persons with problems before they become actual psychiatric patients. These means will make possible more efficient long-range planning for the use of existing psychiatric facilities and personnel and also the better utilization, with or without psychiatric consultation, of such professional persons as social workers, public health personnel, and physicians in detecting and relieving such problems.

What I have just described represents our major research interest which dates back to April, 1957, and was inspired by MacLeod's idea of a "Well-Being Clinic"(9). We raised the question if, in the light of our current knowledge and techniques, it was possible to give any individual a "check-up" on his emotional condition just as it is possible for the physician to give a physical check-up, a dentist to give a dental check-up, etc. This project, on "Mental Health Evaluation of Nonpsychiatric Populations," has developed slowly but surely and now absorbs most of our research efforts. I have already indicated how the project has contributed to a refinement of our clinical diagnostic methods. We have completed, or are completing, mental health evaluations on 89 "normal" subjects. One ex-subject, an industrial leader, has invited us to use his entire organization as an experimental group. Several physicians are interested in, and one is using, our methods to evaluate patients.

Before I close, I should like to make a few remarks about the professional persons who are involved in all of this. To see a need for change is one thing and is relatively easy, but to change is something else again and most difficult. Being the humans we are, we naturally have feelings—sometimes very intense ones—that are intimately entwined in everything we do. To change is at times very painful, for it might involve real or misinterpreted changes in the concept we have of our professional role, status, and prestige and our personal selves (10). We, more so than any other group, should exhibit the kind of patience we have for others going through similar processes. May we have Divine Guidance to help us plot a course through these changing times. May God grant us the wisdom, the courage, and the strength to face these real issues with the maturity that springs from knowing how to "Love thy neighbor as thyself."

In conclusion, it would seem to me that if any mental health center would do these things, that is, develop a meaningful clin-

ical and community program with a related research program, and do them well, it would make a real positive contribution to the well-being of the individual and his community and advance our body of knowledge about man. The satisfactions from such efforts cannot help but be deep and rewarding!

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The use of the survey in mental illness research

The substantive contributions of social scientists in mental illness research often have been brought about by the application of research techniques not usually part of the repertory of clinical investigators.[1] Among the methodological innovations which have proved useful is the survey method (and the structured interview), particularly in assessing public attitudes toward mental illness and in epidemiological research.[2] For the most part, however, the survey has been employed in mental health research involving "normal" populations and not directly or exclusively in investigations of either disturbed persons or their close associates.[3]

The clinical researcher has not encouraged survey studies of mental patients or their families. By virtue of their traditions, training, and research investments, clinicians sometimes feel threatened by the potential application of the survey to "their" patients; the use of an approach so radically different from their own results in accusations of "sacrificing meaning for fact," "losing sight of the individual," and "fragmenting the whole or configuration in

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This paper was read at the 1959 meetings of the American Association for Public Opinion Research at Bolton Landing, N. Y. This research is being undertaken by the Community Health Project directed by Ozzie G. Simmons. The Project is sponsored by the Social Science program at the Harvard School of Public Health and is supported by a grant (M 1627) from the National Institute of Mental Health.

[1] For a recent evaluation of the substantive contributions of social scientists, see Clausen, John A., *Sociology and the Field of Mental Health* (New York: Russell Sage Foundation, 1956).

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[3] Cf. Felix, R. H., and John A. Clausen, "The Role of Surveys in Advancing Knowledge in the Field of Mental Health," *Public Opinion Quarterly*, 17 (Spring, 1953), 61–70.

order to secure discrete units that can be counted." [4]

These and similar issues, of course, are voiced about the use of survey techniques in other contexts and are acknowledged as limitations by survey researchers.[5] Moreover, a number of formidable issues can be raised regarding the specific application of the survey method to the study of the mentally ill. These include:

1. The difficulties of gaining access to an informant population and of obtaining cooperation even when access has been secured; [6]
2. The dangers of upsetting the emotionally disturbed person or his family members; [7] and
3. The problems of obtaining a field staff willing and able to undertake interviews with severely disturbed persons or with others in households where they reside and capable of coping with the range of problems they may encounter.[8]

In comparison with other social research methods—case study and participant observation—the survey is clearly less compatible with the orientations of psychiatrists, clinical psychologists, and social workers whose cooperation is essential, if only to gain access to populations appropriate for study. This was one of the considerations that led to the employment of the case study approach in the initial development of a program of systematic research on the community aspects of psychiatric rehabilitation. Although longitudinal studies of the post-hospital experience of a small number of patients and their associates continue as a major focus of the research program, in the past three years we have also completed two survey-type studies and are presently engaged in the field phase of a third:

1. An exploratory study of 59 former patients and their relatives;
2. An investigation of 182 female relatives of male patients who have succeeded in remaining in the community for at least one year after hospitalization; and
3. A panel study of 500 relatives of formerly hospitalized patients in which the first interview takes place a month after the patient is released, and the second, one year after his return to the community, or sooner if rehospitalization occurs.

This paper chronicles our experience in conducting these studies, with particular emphasis on our completed survey of 182 wives and mothers of male patients who remained in the community for over one year. The substantive findings of the first two studies have been reported in detail and will be reviewed here only to illustrate the usefulness of the survey approach in

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[4] Simmons, Ozzie G., and James A. Davis, "Interdisciplinary Collaboration in Mental Illness Research," *American Journal of Sociology*, 63(November, 1957), 297–303.

[5] Cf. Hyman, Herbert H., *Survey Design and Analysis* (Glencoe, Illinois: The Free Press, 1955).

[6] For example, in one follow-up study of mental patients in the Boston area, less than 50 per cent of the interviews were completed. Bockoven, J. S., A. R. Pandiscio, and H. R. Solomon, "Social Adjustment of Patients in the Community Three Years After Commitment to Boston Psychopathic Hospital," *Mental Hygiene*, 40(July, 1956), 353–74.

[7] In fact, in at least one instance, mental health research directed not at patients or their families but at a total population resulted in undesirable consequences for the community at large. Cumming, John, and Elaine Cumming, "Mental Health Education in a Canadian Community," Benjamin D. Paul (ed.), *Health, Culture, and Community* (New York: Russell Sage Foundation, 1955), 43–70.

[8] Cf. Felix and Clausen, *op. cit.*

mental illness research.[9] In addition to describing the uses of the survey, we examine, in terms of such criteria as loss and no-response rates, the limitations when patients are used as informants and the greater potential yield when relatives are employed instead. Finally, decisions and actions taken which have relevance for promoting the feasibility of surveys are discussed.

USES OF SURVEY METHOD

In our experience, we have found the survey method useful in meeting three research needs:[10] 1) providing parameters and descriptive data, 2) comparing characteristics of mentally ill persons and their families with "normal" populations, and 3) documenting relationships between patients' posthospital performance and characteristics of family members and family settings.

1) *Providing parameters and descriptive data:* Our first survey, an exploratory study of a small number of former patients and their families, was primarily undertaken to provide parameters of a particular subpopulation from a local state hospital. We were asked to undertake this survey by another research group in the area who had completed a "clinical" study of patients and their families. Although this clinical team had gathered considerable data, they had failed to obtain systematically such basic information as the composition of the patient's household, ages and occupational histories of family members, use of community agencies by the family, rent, and income. The use of surveys to provide descriptive data results in the least resistance from the practitioner and is perhaps the most appropriate way of "selling" a study and gaining entree into mental illness research opportunities.

2) *Comparing mental patients with typical populations:* In our other research—longitudinal case studies of formerly hospitalized patients and their families—various facets of the social life of the families appeared quite unusual. For example, a number of the families were residentially unstable, and, among those who had not recently moved, many were constantly seeking new living quarters. These mobility patterns were noteworthy, particularly because of research pointing to a relationship between residential mobility and mental illness.[11] In the survey of 182 families of formerly hospitalized patients, we attempted to ascertain whether or not the mobility of families could be tied to the mental illness. In order to do this, we replicated aspects of

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[9] Davis, James A., Howard E. Freeman, and Ozzie G. Simmons, "Rehospitalization and Performance Level among Former Mental Patients," *Social Problems*, 5(July, 1957), 37–44; Freeman, Howard E., and Ozzie G. Simmons, "Mental Patients in the Community: Family Settings and Performance Levels," *American Sociological Review*, 23(April, 1958), 147–54; Freeman, Howard E., and Ozzie G. Simmons, "Wives, Mothers, and the Posthospital Performance of Mental Patients," *Social Forces*, 37(December, 1958), 153–59; Freeman, Howard E., Ozzie G. Simmons, and Bernard J. Bergen, "Possessiveness as a Characteristic of Mothers of Schizophrenics," *Journal of Abnormal and Social Psychology*, 58(March, 1959), 271–73; Freeman, Howard E., and Ozzie G. Simmons, "Social Class and Posthospital Performance Levels," *American Sociological Review*, 24(June, 1959), 345–51; Freeman, Howard E., and Ozzie G. Simmons, "The Social Integration of Former Mental Patients," *International Journal of Social Psychiatry*, 4(Spring, 1959), 264–71; Simmons, Ozzie G. and Howard E. Freeman, "Familial Expectations and Posthospital Performance of Mental Patients," *Human Relations*, 12(August, 1959), 233–42.
E., Ozzie G. Simmons, and Bernard J. Bergen, "Residential Mobility Inclinations among Families of Mental Patients," *Social Forces* (in press).

[10] Felix, R. H., and John A. Clausen, *op. cit.*

[11] Tietze, Christopher, Paul Lemkau, and Marcia Cooper, "Personality, Disorder, and Spatial Mobility," *American Journal of Sociology*, 48(July, 1942), 19–39.

Rossi's study of the residential mobility inclinations and actual mobility of families in Philadelphia.[12]

Rossi found that both mobility and inclinations to move are the result of an incompatibility between the facilities offered the family in its present housing unit and its housing needs. He was able to predict inclinations to move in terms of such determinants as dissatisfaction with present housing arrangements. For example, one predictor of a family's inclination to move is whether they think there is enough closet space in the present dwelling. We found this to be a problem among families of former mental patients as well; whether it be a typical family in Philadelphia or a mental patient's family in Boston, one out of three households does not have enough closet space and is trying to do something about this. Indeed, most of Rossi's variables predict mobility inclinations among families of former mental patients more efficiently than they did in the original study.[13] Findings such as this have warned us away from making "easy" interpretations of the behavior of families of mental patients as being "pathological and manifestations of maladjustment." [14]

3) *Identifying correlates of mental health:* Although the survey method has proved valuable to us for descriptive and comparative investigations, its most important use has been for testing hypotheses concerning correlates of mental health. In our research, we have documented a number of variables which are associated with the posthospital occupational and social performance of patients who succeed in remaining in the community.[15] Without going into the qualifications, we would like to review briefly some of the findings. The relationships concern correlates of occupational and social performance levels among male patients who succeeded in remaining in the community for over a year:

a) Patients with high performance levels were found in conjugal families and patients with low performance levels in parental families; [16]
b) Low level patients reside with female relatives who are "atypical" (at least with respect to ideal stereotypes in our culture). These relatives tend to be authoritarian, anomic, frustrated, rigid, and withdrawn in comparison with relatives of high level patients; [17]
c) Low level patients reside with families objectively rated lower class and who identify themselves as "laboring class;" high level patients live in fami-

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[12] Rossi, Peter H., *Why Families Move,* (Glencoe, Illinois: The Free Press, 1955).

[13] As another example, see Freeman, Howard E., Ozzie G. Simmons, and Bernard J. Bergen, "Possessiveness as a Characteristic of Mothers of Schizophrenics," *op. cit.*

[14] Tietze, Christopher, Paul Lemkau, and Marcia Cooper, *op. cit.*

[15] We urge caution, of course, in generalizing from our findings. The study group was drawn from a single metropolitan area and consists of patients selected in terms of age, diagnosis, and other characteristics. Some of our findings regarding family settings and posthospital occupational and social performance, however, have been confirmed by studies of Carstairs and associates in England. See Brown, G. W., G. M. Carstairs, and Gillian Topping, "Post-hospital Adjustment of Chronic Mental Patients," *The Lancet* (September, 1958), 685–89, and Brown, G. W., "Experiences of Discharged Chronic Schizophrenic Patients in Various Types of Living Group," *Milbank Memorial Fund Quarterly,* 37 (April, 1959), 105–31.

[16] Freeman, Howard E., and Ozzie G. Simmons, "Mental Patients in the Community: Family Settings and Performance Levels," *op. cit.*

[17] Freeman, Howard E., and Ozzie G. Simmons, "Wives, Mothers, and the Posthospital Performance of Mental Patients," *op. cit.*

lies rated objectively as middle class and who identify themselves as "middle class;" [18] and

d) Parental families with low level patients were found to have more adult males in their households (who can supplement the patient's performance) than families of patients with high performance levels.[19]

APPLICABILITY OF SURVEYS

Our research, like most substantive investigations, has had to forsake the luxury of systematic methodological evaluation. We have attempted, however, to appraise informally the data collection and analysis phases of our studies and to assess the research in terms of criteria such as refusal rate, no-response rate to individual items, and consistency of information between interview and other available data. In addition, we recorded interviewing problems and effects of the interviewing procedure on the informants.

1) *Refusal rate:* The results of our first survey, in which both relatives and patients were interviewed, were quite disappointing as to refusal rate. An attempt was made to interview 59 patients as well as a relative in each household. In less than half of the cases, however, was it possible to interview both patient and relative, and in 16 of the 59 cases, it was not possible to interview either one.

The refusal rate in the second survey was considerably lower. Here we sought interviews only with relatives of patients. Interviews were attempted in 209 and completed in 182 cases (88 per cent). In addition, there were 16 cases in which we could not locate either patient or family. Even if these are included, the loss rate is still under 20 per cent, distinctly low for mental health research, and compares favorably with many market research studies. In our current survey, the loss rate is running below 10 per cent. We believe this lower rate is related to better use of the post office in locating informants, more careful checking of hospital records for addresses, and other considerations which will be discussed below.

2) *No-response rate:* In addition to the high refusal rate for patients, our first study resulted in an extremely high no-response rate to individual items among patients interviewed. Furthermore, it was difficult to "make sense" out of the responses of patients to scale items, suggesting the inapplicability of the survey method to patients. In all our research, however, the no-response rate for relatives has remained reasonably low, ranging between 10 and 15 per cent. We also find that the correlations of items and scales reported in other studies hold for their informants. For example, we found precisely the same magnitude of correlation between anomia and authoritarianism among relatives of patients as Srole did in his original research.[20]

3) *Interviewing the assigned informant:* In all three studies, the interviews were conducted in the appropriate household, but in some cases, rather than the one assigned, another relative was interviewed. In these cases (about 5 per cent), however, the interviewer was able to justify this in terms of language difficulty, absence, or illness of the assigned informant.

4) *Consistency of data:* Although test-

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[18] Freeman, Howard E., and Ozzie G. Simmons, "Social Class and Posthospital Performance Levels," *op. cit.*

[19] Simmons, Ozzie G., and Howard E. Freeman, "Familial Expectations and Posthospital Performance of Mental Patients," *op. cit.*

[20] Srole, Leo, "Social Integration and Certain Corollaries: An Exploratory Study," *American Sociological Review*, 21(December, 1956), 709–16.

retest reliability measures are not available, it was possible to compare the interview data on a number of background variables with information obtained from the hospital records of patients. In terms of these variables, the information obtained in interviews with relatives is consistent with that in the hospital records; ages of household members, for example, rarely varied by more than a year, and such items as birthplace of family members are remarkably consistent between both sources. There is, however, considerably less consistency between patients' responses and hospital record data, again pointing to caution in the use of patients as informants.

5) *Psychological effects:* The field phases of all our research have been conducted, to the best of our knowledge, without any serious psychological consequences for informants, former patients, or even interviewers. While it is necessary to add the qualifying phrase "to the best of our knowledge," the other work of the Project involves continual contact with the hospitals as well as with local social agencies, and it is likely that any serious consequences of the interviews would have come to our attention. We do have telephone calls from persons who are anxious, suspicious, and antagonistic, but we have found it possible to handle these problems in rather ordinary ways, eventually obtaining cooperation from most informants.[21]

In general, then, the evidence indicates the applicability of the survey method to relatives of mental patients but not to former patients themselves, at least not to those diagnosed as "psychotic." [22] The refusal rate, the no-response rate to individual items, and the inconsistencies in responses encountered when patients were used as informants suggest that the survey approach is most applicable when other family members can be interviewed. The limitations when patients are informants probably are related both to the psychological condition of some of the patients and to the anxiety and hostility about "the past" in others whose psychological state may be somewhat more stable.

DECISIONS AND ACTIONS TAKEN

For the most part, of course, the operations carried out during various phases of our studies are typical of, and required in, all survey-type investigations.[23] We feel, however, that certain decisions made and approaches taken expedited the research and merit comment.

1) *Planning and administration:* One of our major concerns in planning the surveys was with "public relations," i.e., developing relationships with hospital and other institutional personnel. Our need for access to records required an extensive program; we sought the collaboration of the state com-

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[21] The most extreme case was the gentleman who came to the office complaining and threatening to mobilize three veterans' organizations against the psychiatric profession.

[22] Other recently completed questionnaire research also indicates the probability of successfully administering structured items to relatives of mental patients. See Freeman, R. V., and H. M. Grayson, "Maternal Attitudes in Schizophrenia," *Journal of Abnormal and Social Psychology*, 50(January, 1955), 45–53.

[23] We might note that surveying families of formerly hospitalized mental patients has, surprisingly enough, some distinct advantages. Certain parameters are available, and the size and many of the characteristics of the study group can be reasonably estimated. Also, having access to hospital records permits, as we have described, an evaluation between the results of our interview, in terms of consistency, with hospital record data on a number of social variables. In addition, we used information from hospital records to evaluate the "honesty" of our interviewers. Cf. Hill, Reuben, *Families Under Stress*, (New York: Harper and Brothers, 1959).

missioner's office and the staffs of 13 mental hospitals.

We first secured the cooperation of the Commissioner of Mental Health and his associates, which was readily provided. Then the "full treatment" given each hospital began with a letter from us to the hospital superintendent, backed up by a letter from the commissioner. Next, we visited either the superintendent or his clinical director and, finally, in most cases, explained the projected study at a meeting of the professional staff. As a consequence of these efforts, we received the necessary support when informants called hospital personnel questioning the legitimacy of the survey.

The importance of an adequate public relations program was brought out by an attempt on our part to "cut corners" in the case of the most distant hospital. This hospital, some 45 miles from the office, did not receive the "full treatment" since they agreed to cooperate after correspondence. At least one of our refusals resulted from this; an informant, after part of the interview, asked if she could continue it the next day because she had an appointment; our interviewer agreed, but when he returned, he was not admitted. She had called the hospital, and her son's physician told her he had never heard of the Community Health Project, and she should not answer any more questions.

We reached the decision early in the prefield phase to employ psychiatric social workers or other clinically sophisticated persons as interviewers. Not only were their backgrounds and skills deemed appropriate for our interviewing needs, but the fact of their employment helped "sell" the study to hospital personnel. Also, it provided insurance against the raising of the issue that we had not taken every precaution in the event that an informant were to become upset by the interview experience.

A by-product of the public relations program with the hospitals was the opportunities it provided for obtaining candidates for the part-time interviewer jobs. Before we interviewed each candidate we consulted either our staff psychiatrist or staff social worker. In almost all cases, we secured information on their capabilities and experience prior to the hiring interview in which we really sold the job instead of evaluating the applicant.

It also seemed advisable to notify informants in advance of the interview. A letter was sent describing the proposed visit; it explained that the information obtained would be useful in improving the post-hospital treatment of patients in the future. The letter specified, as an explanation of how we knew about the family member's illness, that the hospitals were collaborating with us, but it also assured informants that information would be kept confidential from hospital personnel as well as from others. Along with the letter, informants received a self-addressed postcard in case they cared to indicate a convenient time for the interview. About one-third of the cards were returned. Of course, even if we did not receive a card, an attempt was made to complete the interview.

These letters were sent ordinary mail, but the envelopes were stamped *"Postmaster: Do Not Forward, Return To Sender."* Each one returned to us was sent out "certified mail" with a request for the new address. This procedure enabled us to locate families who had left forwarding addresses. In our current survey we are sending all letters "certified" and paying the fee for receiving the informant's current address. This appears to raise interest on the part of the post office in delivering the letters and to emphasize the importance of the survey to informants who do not

appear to find receipt of certified mail upsetting. It is necessary, however, to stamp the envelope *"Postmaster: If Not Delivered In Five Days, Return To Sender,"* since certain informants are extremely negligent about picking up even certified letters from the post office. Since we do know after they are returned if the address is correct, we then send the letter again via the regular mails.

The public relations program that is required will vary, of course, from study to study in mental health research as it does in all survey investigations, but it is likely to impede the researcher drastically if neglected. During the pre-field phase of our current study, we have continued the information program with hospital personnel and extended it to other community persons whose aid, advice, and assistance are required. For example, a number of the families included in the study group live in public housing projects. Sometimes it is difficult to locate an apartment because the names have been scratched off the directories by children in the neighborhood. Attempts to obtain the apartment number from tenants in the project are usually unsuccessful, since the interviewer is perceived as a bill collector or policeman. We then arranged to secure apartment numbers from the city housing authority, a procedure requiring several contacts, letters, and telephone calls to various city officials before such cooperation was forthcoming.

2) *Interviewer training:* As we have reported, our public relations program with the hospitals netted us a large group of psychiatrically trained persons from whom we selected our interviewers. In both the completed study of 182 cases and the study presently in the field, we conducted similar training programs. Three meetings were held with the entire interviewing staff (which in the new study is 26 persons), and a fourth with either individuals or with three or four people at a time. At the first group meeting, the purpose of the study was explained. We have had to balance the problem of telling interviewers enough about our study to keep them motivated and interested without telling them so much that the study might be influenced by their biasing the results either for or against us. Our policy has been to offer a general and somewhat vague explanation of the study and never to point up specific hypotheses. On the other hand, we have always provided accurate information in response to direct questions. Since publications of the completed research are available to many of the interviewers, and indeed "required reading" for some of them by the hospitals in which they work, many of them have more knowledge of the study now in the field, which is in part a replication of the previous one, than we think is desirable.

At the first meeting, we also discussed such interviewing procedures as ways of contacting informants and establishing rapport. Since our field workers are persons with a considerable investment in interviewing techniques, these discussions were more of an exchange between professionals than didactic training sessions. Indeed, we modified certain of our views on the basis of these discussions; for example, we felt that telephone calls should not be attempted in contacting informants but that the interviewer should approach the person "cold." [24] The majority of the interviewers disagreed, and we decided to leave it to their discretion, at least during the pretest.

Since there were no refusals when telephone calls were used, we permitted telephone contacts throughout the study and found no differences in the refusal rate for

[24] Cf. Goode, William J., *After Divorce* (Glencoe, Illinois: The Free Press, 1956).

these cases as compared with those in which the initial contact was face to face. This is, of course, not to recommend the indiscriminate use of the telephone for arranging interviews, although it does save considerable time in call-backs for informants not at home. The probable reason our interviewing staff is successful with telephone contacts is that, being social workers who use this approach in their regular job activities, they have a well developed "telephone role." If interviewers without such experience were employed and telephone contacts were desirable, we would certainly want to utilize role-playing techniques before employing this procedure.

The second meeting was primarily for discussion of the pre-test interview schedule. Each interviewer was then assigned a case and conducted an interview. This procedure not only yielded us a number of pre-test interviews but gave an opportunity for each interviewer to practice with the schedule. When the pre-test interview was completed, an individual conference was held with each interviewer or with small groups of interviewers if they worked at the same agency or hospital. We not only considered specific interviewing problems but requested and received many excellent suggestions on question wording, question order, and ways of reducing anxiety of informants by modifying certain introductory stems.[25] At a third group meeting, the final interview schedule was discussed and administrative problems reviewed.

In discussing our studies with survey researchers, the use of social workers as interviewers has evoked considerable comment, particularly with respect to their willingness to interview with a structured schedule. We are convinced that it is the type of relationship developed with the field staff that determines whether they will accept this interviewing approach. It must be made clear to them that their role is one of interviewer and not one of research collaborator; and that although they are professional people, they are not in this case responsible for the research methodology. This view must be mentioned throughout the study, and one does find it necessary to take the drastic action of dropping interviewers who will not cooperate fully. Despite our "toughness," we have had a reasonably stable field staff. For example, in the new study, after four months of field work, we are still employing 23 of the 26 interviewers originally hired. We believe that this stability is due not only to the way in which we have defined and conducted our relationship with the interviewers but to the financial compensation we have offered as well. It is only realistic to state that, apart from any other considerations, good performance from interviewers can be expected only if fair remuneration is received. To that end, we have paid $10.00 for each two-hour interview plus remuneration for travel time, mileage, and any time for conferences that may be required.

3) *Field work:* After the last interviewer meeting, we assigned each interviewer two cases. Completed interviews are replaced by mail as they are returned. Two weeks are allowed for completion of an interview. In our current study, the interview must be

[25] One of the major problems raised was the responsibility of the interviewer to informants who requested advice and assistance. In our completed study, since we did not intend to follow up informants, we indicated that while no direct assistance should be offered, we had no objection to the interviewer's referring the person to an appropriate agency. We estimate referrals occurred in between 15 to 20 per cent of the cases. In our present study, however, such a procedure would do violence to our two-stage design. Therefore, we have insisted that no referrals or other assistance be given during the interview.

completed as soon as possible after the patient has returned to his family setting; thus, deadlines are held to inflexibly with few defections.

The refusal rate in our current survey, as noted, runs under 10 per cent. In about half the cases where we are initially met with refusal, the interview is ultimately completed. A number of these cases are obtained by assigning the informant to another interviewer. For example, in some Italian families, male interviewers are not accepted by married female informants. Cultural variations are considered in initial assignment of cases, but the practical problems of matching interviewers to informants limit this procedure.[26]

As a last resort, we have sought the hospital's aid in obtaining an interview. In some cases, a letter from the hospital superintendent has allayed an informant's distrust or reluctance, while in others, a hospital staff member has helped us through a telephone conversation with the informant. We are aware of the biases that may be created by such pressure, but we have adopted the view that an interview secured in this way is better than none at all.[27]

The field phase in both our large scale ventures has developed into a routinized situation, wherein the major problem is the formidable clerical task of assigning and processing interviews. In the current study, many of these clerical operations have been simplified by using an I.B.M. system for listing and keeping track of interviews. At the time the case is assigned to an interviewer, we have an I.B.M. card punched with basic information including the names of the patient and the relative to be interviewed. As the interview is completed, we add this information to the card. Each week we list these locator cards by a variety of sorts: alphabetically, the interviewer assigned to the case, the status of the interview, the hospital from which the case is drawn, and so on.

Although cases are assigned by mail, we have frequent personal conferences and telephone conversations with interviewers, for questions arise continually regarding interviews. Whenever conferences are necessary, or the interviewer has had to visit the informant a second time through no fault of his own, we have increased the remuneration for the interview. Likewise, a higher rate has been offered as an incentive to have another interviewer try refusals and to motivate interviewers to call back in cases where informants cannot be easily located. It is difficult to estimate the costs involved in our studies, since some staff members participate in other project research as well. The field work comes to about $25.00 per case, and if case selection procedures, coding, and office processing are included, we estimate that each completed interview costs four times this amount.

CONCLUSION

Our experiences in the use of the survey indicate that this approach can be advantageously employed in mental illness research. The problems encountered and

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[26] In our studies, we have been concerned only with native-born patients, which has reduced considerably the number of foreign-born informants, even though parents of patients may be immigrants. The language problem, nevertheless, has been a major factor in our refusal rate.

[27] The interviews in our studies last about two hours. We find one need not worry about the length of the interview. From the comments of our interviewers, it appears that if there is any strain, it is on the part of the interviewers not the informants. This impression confirms the observation that respondents rarely show any strain or desire to terminate an interview even if it lasts for hours. Gross, Neal, and Ward S. Mason, "Some Methodological Problems of Eight-Hour Interviews," *American Journal of Sociology*, 59(1953), 197–204.

the limitations imposed are no greater than in most types of survey research. On the basis of our experience, we conclude that the success of surveys in this field is primarily dependent upon the systematic application of sound principles of survey research.[28] There are, however, special considerations that the researcher will do well to take into account. For example, we are convinced that our decision to use social workers was fortunate, and we would now be somewhat reluctant to undertake a study employing interviewers without social work backgrounds. On the other hand, our experience suggests that perhaps the social scientist has oversold himself about the special nature of mental illness research and the inapplicability of much of his methodology.[29]

The survey approach has its limitations in mental illness research as in whatever field it is applied, but judicious application yields substantive findings that constitute a much-needed increment to systematic knowledge in this field.

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[28] Cf. Caplow, Theodore, "The Dynamics of Information Interviewing," *American Journal of Sociology*, 62 (September, 1956), 165–71.

[29] This is, of course, at variance with the view presented in Luszki, Margaret B., *Interdisciplinary Team Research: Methods and Problems* (New York: New York University Press, 1958).

IRVING BLUMBERG

Some orienting concepts for an effective mental health movement

Every organization which aspires to serve its community successfully must periodically pause to redefine the goals it has set, to take stock of its achievements, shortcomings, and resources, to re-infuse its sense of dedication, to sharpen its tools of services, and to reaffirm or modify the direction in which it proposes to travel.

With the bourgeoning progress of the National Association for Mental Health, the need for such periodic stock-taking becomes particularly compelling. True, the formal occasion for evaluation customarily takes place at the annual meeting. The 1959 Annual Report of the NAMH bears eloquent testimony to the marked progress already achieved. In addition, reappraisal sessions by state and county affiliates undoubtedly result in constantly improved work.

What, then, is the specific focus of this paper? It is the writer's hope that the observations of a lay participant at a county level may add a somewhat different perspective to the customary critiques.

In the hurly-burly of the day-to-day work —administering an office, planning a fund campaign, and responding to specific community needs—there is sometimes a tendency to lose sight of the trees for the forest. It requires an authoritative statement like the following to stop us in our tracks and force upon us an urgent reexamination of the fundamental socio-philosophic premises of our work:

"Tens of thousands of mentally ill patients in our nation today are receiving disgracefully inadequate care and treatment."

. . . "The resources we are devoting to mental illness today falls dreadfully short

Mr. Blumberg, a member of the New York City advertising firm, Blumberg & Clarich, Inc., is vice-president of the Bronx County Society for Mental Health and a vice president of the New York State Association for Mental Health.

of meeting the problem. We have not yet mounted an effective attack on mental illness in this country"—from a statement by Arthur S. Flemming, Secretary of Health, Education and Welfare at a press conference on April 20, 1959.

In the face of such a devastating judgment of need, we in the citizens' mental health movement had better ask ourselves some searching questions: Just where in the total constellation of forces, both public and private, does a citizens' mental health movement fit? What are its potentialities and its limitations in dealing with the massive and protean problems of mental illness?

More specifically, what constitutes a proper balance of effort in terms of staff commitment, use of financial resources and program planning between the work of the NAMH and its state and county affiliates in their capacity as a direct-supplier-of-needs, and their concurrent role as a community conscience, a catalyst, a prod, seeking to extract urgently needed funds from reluctant government authorities?

This is no abstract problem. As a matter of fact, the resolution of this basic problem of goal orientation confronts staff and lay boards at every turn. For example, to what extent is an association affiliate justified in using its all-too-meager resources to make direct research grants to public or private agencies? When is it justified in starting or helping to finance a mental health clinic or other pilot project, or to provide a professionally staffed referral service at headquarters? Alternatively, in what situations should it consider itself obligated to generate community pressure, by means of delegations, public pronouncements or direct lobbying on government agencies in the quest for adequate appropriations or legislative improvements?

If we are to judge by the documented specifications of needs appearing in the 1959 NAMH bulletin, *What Are the Facts About Mental Illness?* we are constrained to apply a yardstick heavily weighted in the direction of the latter approach. Clearly, unmet needs are so vast that only a government-financed program of research, care, treatment, and rehabilitation can hope to make any appreciable dent in the situation.

This fact places upon a voluntary citizens' mental health movement the responsibility for shifting its main emphasis from what it does *directly* in providing funds or services to what it gets *governmental* units to do in the many-faceted attack on mental illness. This is not to minimize the indispensable role which such a citizens' movement must play in the sphere of public education and information. Certainly it is our unique task to provide the public with the essential facts and to develop sound attitudes with regard to the problem of mental illness. Additionally, it is our responsibility to foster community acceptance of modern concepts of treatment, care, and rehabilitation and to quicken the public conscience to the crying need for humane treatment of the mentally ill.

When we attempt to relate mental health needs to a rational concept of national security and welfare, or when we seek to determine the appropriate relative supportive roles of private initiative and governmental responsibility in this area, the following supposition might serve to clarify the emphasis I wish to convey. If we were told, for instance, that a hypothetical enemy proposed to blanket the United States with a nerve gas which would mentally debilitate 17,000,000 Americans, we would without question consider this an emergency of the very highest order. An all-out mobilization would be declared. Fantastic sums of money would be instantly appropriated to

ward off this devastating blow or, if the blow had already fallen, to repair the damage. No consideration of financial stringency, of inflationary pressures, or of mounting debt would be permitted to stand in the way of timely preventive or curative action.

Does it not logically follow that the interests of national security require us to assign a top order of priority to the expenditure of public revenue at least remotely commensurate with the fact that *we do have* 17,000,000 Americans categorized in varying degree as mentally disturbed or ill. The writer is well aware of the alleged stringency of available public funds at all levels, city, state, and federal. Yet, in a democracy, the people must ultimately be the judge of whether education, public health, housing, and mental health are receiving their just share of the community's total resources.

The foregoing comments are not intended to imply an inherent dichotomy of interests in the work of a citizens' mental health movement. Rather, they are designed to provide the basis for a rationale in determining proper limits of responsibilities between the private and public sectors of the forces arrayed in the battle for mental health.

SOME PRACTICAL FACTORS IN A COUNTY SOCIETY'S WORK

While the socio-philosophic concepts herein discussed are central to the formulation of broad policies as well as specific decisions in our work, there are other facets of a citizens' mental health movement which merit consideration. The writer's limited experience at a county level in a large metropolitan center (New York City) leads him to a number of tentative observations. These observations are not offered in any censorious sense, but as impressions based on conservations with a number of staff and non-staff persons in a number of local affiliates, as well as participation in board work at a county and state level over a period of two years. To the extent that they bear any stamp of validity, their consideration may lead to a sharpening of our tools of work.

1) There is a *lack of specificity* in much which passes for educational work in the community.

   All too often our educational efforts appear to be diffuse in nature, inadequately thought out in content and purpose, and undirected so far as their impact on target or leadership groups are concerned.

   In planning our educational work we simply do not sufficiently spell out the specific end-goals, facts, motivations, and principles which we are seeking to impart.

   It is a reasonable assumption that this, in turn, is a consequence of a certain fuzziness in our own thinking as to exactly what values and principles are subsumed in the concept of "mental health."

2) Adventitious factors too often determine the *programmatic work* of our local groups. We are not sufficiently and continuously at grips with the hard-rock realities of our work; we do not always closely relate our work to the ultimate "commodity," the human being in distress.

   There must be, consequently, more specific planning of programmatic work for a specific period of time. This lack of specifically stated, time-scheduled goals is evi-

dent at all levels, county, state, and national.

If this statement is substantially true, how can we reasonably expect to mobilize the total resources of a volunteer citizens' movement into the most effective channels? A sound mental health program should, in the writer's opinion, be:

a) Adequately *publicized* within and outside the association.

b) Adequately *coordinated* so that all units at all levels can cooperate to achieve common goals—particularly in matters involving federal, state or local budgetary and legislative improvements.

c) *Specific* in value, *limited* in scope, *achievable,* and related to the known needs of our various communities.

Here it may be added that a detailed acquaintance with one's own community's needs and resources is a *sina qua non* for effective work. Such knowledge which does exist is all too often concentrated within staff and is not made the common property of lay boards.

d) Formulated in a definite *order of priority* so that staff, committee, and board workers can be guided in their allocation of time and so that *primary* goals receive *primary* attention.

While it is true that the local associations must give due weight to local needs, sight must never be lost of some basic mental health goals which transcend local geographical boundaries. The following quotation will help us keep our feet on the ground:

"Our most urgent concern is for the hundreds of thousands of people who are wasting away in mental hospitals, unable to get the attention, care, and treatment they need."

"Progress in the fight against mental illness must be measured in these ultimate terms: How many people improve and recover after treatment? How many cases of mental illness can be prevented?" (From the 1958 Annual Report of the NAMH)

e) Adequately spelled out in terms of an effective program of *action.* All too often, useful surveys are made and plans developed, only to be left to moulder in the file of good intentions.

3) Local research grants are sometimes given without relating the grant to any overall view of a society's total budget and resources, to proper professional screening, or to coordination with research grant needs on a larger geographic basis. Grants are sometimes approved as a "public relations" gesture to show the public "what we are doing" with their funds and to justify our existence to state supervisory agencies.

Sight should never be lost of the fact that the only justification for solicitation of public funds rests with the practical programmatic work of a society.

4) The raising and disbursing of funds absorbs a disproportionate amount of staff and board time in comparison to time and effort expended in specific, constructive programmatic work.

5) There are too many months of relative inactivity (so far as committee,

board, or programmatic work is concerned) during the year. Mental health needs do not take a vacation from June through September, nor in December.

6) Board agendas are too often loaded with routine, peripheral and inner-administrative problems to the virtual exclusion of matters of primary concern.

7) State and national associations do not call upon local affiliates to lend support to specific objectives which transcend local interest.

While recognizing the enormously complex financial organizational problems which our national and state associations have to grapple with, it is nevertheless true that their *prime* responsibility lies in the area of coordination and program leadership in their respective fields of jurisdiction.

8) Fund-raising itself is becoming an increasingly serious problem and must be viewed in the context of multi-fund pressures upon an increasingly resentful public. The present chaotic conditions cannot but seriously impair our effectiveness as a citizens' mental health movement. A serious, realistic tackling of this problem, despite its admitted intricacy, cannot be postponed for long.

9) County societies in a large metropolitan area must learn to discard provincial approaches and must begin to develop an effective coordinating mechanism on fiscal, organizational, and programmatic levels. Such coordination is simply indispensable in dealing with city-wide needs. Staff predilections or narrow concerns which, in any degree, conflict with the effectuation of sound overall policies, must not be permitted to stand in the way of necessary coordination. The merits, and only the merits, must be the determinant in the solution of inter-county or county-state problems.

10) The whole area of fiscal responsibility, definition of income for purposes of allocation as between counties, (especially in metropolitan areas) state and national society to permit maximum efficiency at all levels is a serious problem requiring the most immediate and painstaking attention in order to arrive at a dispassionately intelligent solution.

11) While professionally-serviced headquarters' referral work is an essential part of a local society's work, there appears to be an overemphasis on this aspect of a society's total programming.

12) There is also a tendency, natural to lay boards, to equate all types of treatment methods and facilities as equally efficacious.

It is not here suggested that the society attempt to pre-empt the area of professional judgment as between the various schools of therapy, modes of treatment, facilities, etc.

Nevertheless, it cannot remain indifferent to the advance of modern scientific technology and validated concepts in the field of treatment. It must, with competent professional advice, evaluate the therapeutic contentions of psychoanalytic schools, of psychopharmacological or other physiotherapeutic approaches in its effort to stimulate the use of the most effective treatment possibilities for the mentally ill.

Reliance, in the main, on pervasive psychoanalytic approaches and resist-

ance to the advancing trend of empirically validated physiotherapeutic techniques, where indicated, can only serve to retard progress and improvement for tens of thousands of mentally ill persons.

13) Once a psychiatric facility is established, there is a tendency to assume that all is well. The need is presumably met. Such a satisfying conclusion, of course, is not always warranted. Adequacy of professional staff, both in numbers and quality, continuity of the doctor-patient relationship, as well as the technical and philosophic approach to treatment procedures are all important elements in determining whether and how quickly a mentally ill person is helped.

CONCLUSION

The above observations and criticisms are not offered as typical or representative of any single county, society, or group of societies. Enormous improvement in skills and application is constantly in evidence. What is suggested is the need for an ever-critical and cautionary view of our work. The end is what counts, and the end product of our labors is a happier, healthier community.

S. STEVEN ROSNER

Aftercare services for the mental hospital patient

A survey of 10 state mental hospitals in Pennsylvania

New methods in the care and treatment of the mentally ill in the United States, together with the widespread use of chemotherapy, have resulted in a drop of 13,000 in the number of patients in state mental hospitals today, compared to three years ago. Pennsylvania's state mental hospital population has decreased about 2,000 in the same period. These decreases have reversed the steady upward trend which prevailed for more than a generation.

However, more and more patients are being admitted to mental hospitals. Short-term treatment is getting many of them back home, and drugs are helping to keep many from returning to the hospital. So far, re-admission rates have not begun to climb. How long this progress can be maintained in the face of a rapidly growing national population will depend not only on the drugs but on the amount and quality of aftercare services developed by the hospitals and on the response of the community in helping the discharged patient make a satisfactory psychiatric, social, and vocational readjustment. Failure in either of these areas may mean a return to increasing populations in the hospitals.

Dr. Saul H. Fisher, in his paper, "The Recovered Patient Returns to the Community," [1] warns:

"The decision for (hospital) discharge is not only a medical decision; it is a social one as well, just as the decision for hospitalization is based on social as well as medical reasons. . . . The patient is not 'cured,' as a rule, and he still may have symptoms. . . . Patients with tuberculosis may be 'arrested' but not cured. . . . So it is with psychiatric patients . . . unless condi-

Mr. Rosner was formerly Eastern Pennsylvania area director for Pennsylvania Mental Health, Inc., Philadelphia, Pa. He is now executive director of the Maryland Association for Mental Health, Baltimore, Md. Mr. Rosner began this study while a staff member of PMH, Inc. The analysis and opinions expressed are his own.

[1] *Mental Hygiene*, 42(October, 1958), 463–73.

tions after discharge are favorable, a relapse may occur, and the patient will be re-admitted to the hospital. About 30 per cent experience this the first year after discharge."

Dr. Fisher calls for an overall rehabilitation program which ensures the psychosocial and vocational rehabilitation of the mental patient. He notes:

"Rehabilitation must begin in the hospital, from the very point of admission. . . . Much has been learned in recent years, and excellent programs have been instituted in several hospitals." After reviewing these programs, he says that "the idea is to treat the patient as a totality, not as a series of parts, and only a truly integrated program can achieve this. This would require close coordination between the hospital, the rehabilitation center, and the community, and this can be achieved only with the full cooperation of all governmental, community, and private agencies."

Dr. Fisher's position is corroborated by Dr. Robert C. Hunt, Dr. George S. Stevenson and Dr. T. J. Boag (see bibliography). The most comprehensive encyclopedia of aftercare services for mental patients is contained in the publication "After Care Services for the Mentally Ill—A World Picture," by Lee T. Muth, Chief, Social Work Service, Veterans Administration Hospital, Huntington, West Virginia (published by the Mental Health Education Unit of Smith, Kline and French Laboratories, Philadelphia, Pa.)

In April, 1957, Pennsylvania Mental Health and Philadelphia Fountain House co-sponsored a conference concerned with the coordination of community resources in psychiatric aftercare. The conference was made up of individuals from the various psychiatric professions who had pioneered in the field. They came from different parts of the United States and from Canada. Papers describing various projects in aftercare were presented and discussed.

One trend noted at this conference was, to quote the report of the proceedings, "the crumbling of the wall which for so long has divided hospital from community." It noted that "the hospital is only one phase of the treatment process. The community must carry part of the program with the family—or even with the patient himself. . . . It follows that the community and the hospital must work together."

The conference was in agreement that aftercare services could be rendered by community agencies and personnel including "the public health nurse, the general practitioner, the minister, service agency personnel, and other competent persons. . . ." Cooperation between the hospital and the community was stressed as the essential factor.

The hospital knows that often patients considered psychiatrically ready to go home face the risk of not making a satisfactory adjustment to family and community life. Many would have to go back to families not able or willing to take them back; this emphasizes the need for foster homes (or possibly rooms at the "Y" and elsewhere) and social centers (Fountain House) which could help them make an adequate social adjustment. Other patients may need a job more than anything else in order to make an adequate adjustment on leaving the hospital. Saul H. Fisher, in *Mental Hygiene* (October, 1958) notes that "work is valuable not only as a preventive for deterioration but as a vehicle for social rehabilitation." Boag makes a similar point in his paper "Rehabilitation in Mental Health" (Pennsylvania Mental Health, Inc., publication). Both Doctors Fisher and Boag favor foster homes and social clubs as well.

Halfway houses help the hospital staff

prepare the patient for normal family living, for independence, and for some work experience.

A "Big Brother" role is suggested by Dr. Boag, who refers to it as a "Special Volunteer Program;" he says it "is something like a 'big brother' program. For patients who we feel need a good deal of support which they are not able to get from their families, or where they have no family, we have a volunteer who is willing to try to fill this gap. To see the patient regularly, to provide support, friendship and companionship. . . ."

Mental health associations have sought to contribute to the task of promoting aftercare assistance to mental patients so that they can make satisfactory psychiatric, social, and vocational readjustments. However, in order that we might know the size and nature of the problem, we undertook a study of aftercare services and the role played by Pennsylvania's state mental hospitals in such services. We did not know how many patients were being furloughed or placed on extended home visits or what happened to them prior to their final discharge by the hospital. We did not know what contact the hospital staff had with these furloughed patients, what the nature of the contact was, and if there was a serious gap between what the staff did or was willing to do and what the furloughed patient needed and should have to make a satisfactory adjustment to his family and community.

These were some of the questions that prompted a survey of 10 of our 16 state mental hospitals (excluding the hospital for the criminally insane which presents unique problems). For geographical reasons, the six hospitals in the western part of the state were not visited. The survey was conducted during February, 1959. Meetings were held with the hospital superintendent and/or the director of social service, clinical director, or other personnel the superintendent felt should participate.

In the course of the survey, many differing attitudes were expressed by the hospital personnel about the need or wisdom for various kinds of aftercare services such as foster homes, halfway houses, out-patient clinics, social clubs, liaison with other social agencies, etc. One superintendent questioned the wisdom of any aftercare contact once the patient left the hospital. These viewpoints are incorporated into this survey report.

THE NATURE OF AFTERCARE SERVICES

Each hospital carries on its rolls those patients actually within its walls and those who have gone home on trial visits (called furlough or probation in some hospitals) of an extended nature. While on these home visits the patient can have his case reviewed by the medical staff and, if the staff considers him well enough, he may be permanently discharged; at this time his name is removed from the rolls, and the hospital no longer has any legal responsibility for him. Patients may be discharged any time during the first three years after they leave the hospital, but discharge becomes mandatory after the three years are up, unless the patient returns to the hospital for as long as 24 hours prior to that time. Some patients do this in order to maintain contact with the hospital or to make formal recommitment at a later time unnecessary.

While getting ready for furlough or extended home visit, and after leaving the hospital, the patient may have the following services:

1. Help in preparing his family for his return home. This can be given by either medical or social service staff.

2. Help in finding other suitable living arrangements if the staff feels he should not return home, or if there is no home to which he can return. Such arrangements may mean a foster home in the community, a room in a rooming house, YMCA, religious mission, etc. Or he may need to be placed in a county home or institution for the aged.

3. The hospital out-patient clinic where the patient is seen periodically to ascertain his psychiatric progress is often the means for checking on his progress in drug therapy and to prescribe another supply of drugs.

4. The hospital social service department may arrange to keep in touch with the patient by mail or by visits to his home or by contact at the out-patient clinic or special office run by social service in the nearest town to the patient. Social service, in turn, may advise the patient about contacting social agencies in his community (public assistance, public health or visiting nurses, family service, psychiatric clinic, etc.) and may help him make such contact although stopping short, usually, of an actual referral.

5. Rehabilitation services may be provided by the hospital and/or by the community. The hospital may work together with the Bureau of Vocational Rehabilitation to help find employment for the patient. It may establish living quarters on hospital grounds where the patient can learn once again to live in a family setting and work in the community during the day.

Special community services are being organized to help the patient in his social reintegration. These projects have been termed social clubs, friendship rooms, Fountain Houses, Recovery Inc., etc. They try to help the patient resocialize with citizen volunteers in his home town who, in turn, seek to bridge the gap from the hospital back to the patient's old social contacts—his church, fraternal club, old friends, etc. Some communities outside of Pennsylvania have established residential centers for ex-mental patients and have helped them in making an economic and vocational as well as a social readjustment.

What this survey shows is that each hospital has engaged in some or all of the above functions, depending on its needs and resources, on the attitude of its superintendent and staff, and on community attitudes and resources. Some hospitals have sought out individuals and groups in the communities to assist their furloughed patients. Other hospitals have confined themselves to preparing the patient for his return home; once the patient leaves the hospital he is considered well enough to cope with his problems without further staff assistance. Some hospitals fall in between these two extremes.

THE SURVEY

The 10 hospitals surveyed have a total patient population of over 24,000. Approximately 6,800 additional patients were listed as on "extended leave status," on "furlough" or "probation," the terms being used interchangeably to refer to those patients who have not been legally discharged and are still carried on the books of the hospital. About 1,900 furloughed patients who have been out for varying periods up to three years returned to the hospital during 1958, a re-admission rate for this group of about 28 per cent.[2] Over 4,100 of these furloughed patients went on leave during the year 1958. Re-admission rates have to be considered in light of the purpose

[2] None of these figures are exact, ranging as they do from data taken from carefully kept records to "educated guesses" by the social service departments of the hospitals.

of the hospital staff in placing patients on furlough. Dr. T. J. Boag at Allan Memorial Institute of Psychiatry, where pioneering work has been done in modern treatment methods, has suggested that any time which a patient can spend at home in his community may be a positive achievement for him as well as for the hospital. A re-admission "always requires interpretation," he warns, "as it may often be quite a desirable feature in the treatment of a particular case."

Living Arrangements

Most of the patients on furlough are back with their own families, the specific hospital estimates varying from "over 95 per cent" to "about 99 per cent." Less than two per cent of the total were placed in foster or boarding homes. One hospital had placed 52 patients in a county home for the aged, and another hospital had placed about nine per cent of patients furloughed during 1958 in foster homes; this latter hospital has had an active foster home program since 1932. This program began by advertising in the local newspapers and by having staff members agree to open their homes to patients on leave. Another hospital has 20 patients in a nursing home.

In most cases, the Department of Public Assistance has provided funds for placing patients in nursing or boarding homes. But DPA has a legal restriction against paying for anyone who is still mentally ill, which often raises the question whether a patient furloughed from the mental hospital must still be considered mentally ill. One hospital has found that its county home for the aged will accept furloughed patients without DPA funds but only if the hospital, in turn, will take someone the county home feels needs to be committed. This may benefit the patient being furloughed and possibly the newly-committed patient from the home, but the hospital feels it is not an ideal arrangement.

One hospital does not see a need for foster homes except in work situations where patients serve as domestics or farm laborers; it feels it handles these situations satisfactorily. Two hospitals feel they have more foster homes than they need and are doing an adequate job, mainly through social service, in finding suitable homes when needed. Two other hospitals find they are pressed from time to time to find suitable homes, but that they generally manage to find them, and that they would do a better job if they could employ more social workers; they do not favor help from citizens' groups like the mental health association since they feel it requires professional direction. The remaining five hospitals vary in the effort they put into foster home placement, ranging from those who do only an occasional placement from time to time, to one hospital which has an active placement program; but all five of these hospitals indicated that they see a need for help with this problem from a local mental health association. They are willing to explore this further with their county association.

Less than two per cent of all furloughed patients are living in single rooms, their own apartments, or in a "Y", Salvation Army residence, Rescue Mission, religious home, etc. Two of the hospitals reported as many as 10 per cent living in such quarters, usually individuals who had found jobs and were trying to be wholly or partly self-supporting.

Clinics

Only five hospitals have out-patient clinics where they see about 1,500 furloughed pa-

tients, usually on a monthly basis. They are generally on heavy drug therapy and are seen in order to check on the therapy and to provide the patient with another month's supply of free drugs. Four more hospitals said they want out-patient clinics and would establish them if they were given enough funds and staff. At present these latter four hospitals can give furloughed patients enough drugs for only a few days or a week and a prescription for their family physicians. The family physicians often fill such prescriptions for months or years without ever seeing the patients, according to one superintendent. One hospital which refers 99 per cent of its furloughed patients to their family doctors sends the doctor a summary of the patient's condition and invites the doctor to contact the hospital at any time about his patient. Some hospitals will refer patients to community psychiatric clinics. But in all planning with patients for help from clinics, DPA, or social agencies, the hospital limits itself to suggesting that the patient contact these agencies and will only make a specific appointment if the patient requests it.

The feeling on the part of some superintendents is that once the patient leaves the hospital and goes on furlough he should assume responsibility for his own care, including appointments with clinics or social agencies. There is a reluctance to hold on to the patient. As one superintendent put it, the mental hospital has no more "proprietary interest" in an ex-patient than a general hospital does in a former physically ill patient. The rationale is that most patients resent further contact from the hospital as interference and an attempt to keep them tied to the institution. More than 75 per cent of furloughed patients are thus not seen by clinic staff or social service, and only a fraction of them receive follow-up questionnaires to determine how well they are adjusting to home life.

Social Service

Social Service sees about 1,800 furloughed patients during the year, mostly in conjunction with the out-patient clinics of the hospitals where the social worker prepares the case for the medical staff or does some supportive therapy with the patient or his family. The social worker arranges appointments by letter or phone. In one hospital, the social service department is responsible for manning a clinic in town; in another hospital, social service has an office in town. Supportive therapy is done in the former, under medical guidance.

Contacts with families of patients are very limited at present, only one hospital having organized a program for regular meetings; it holds monthy meetings in cooperation with a community civic group, and an average of 40 attend. Three other hospitals see relatives before patients are furloughed; three have occasional contacts with relatives who call or come in to see the ward physicians or social service. Three more hospitals would like to establish regular orientation sessions with relatives in order to develop insight and understanding and thus make the transition to home easier for the patient. Two of these hospitals used to hold such sessions and would do so again if they get funds and medical staff to make it possible.

Social service usually prepares a patient for furlough, although in some cases this may be perfunctory, the decision having already been taken by the medical staff. Only in three hospitals does the social worker send routine letters to the patient's family inquiring about his home and social adjustment. Such questionnaires may be very simple or very thorough in exploring the patient's condition, feelings, etc.; they

may be sent every three or six months or just on his annual date of furlough. They are evaluated and prove helpful in deciding if the patient should be discharged before his three years' probation are up. In some cases they might indicate a need to have the patient return to the hospital.

The other hospitals send letters to a few patients who may have special problems. In six of the hospitals, home visits are made where the patient becomes a problem, but none have a regular policy of home visits. Two hospitals used to visit the homes of all furloughed patients but gave this up as too time-consuming and because they felt very little good was accomplished. Except for the 1,800 seen in out-patient clinics and town offices or by social service, the hospital staff has almost no contact with those on furlough. Some patients may call or write or drop in to see their ward physician or social service worker, usually on visiting days, but no systematic program for follow-up has been instituted.

Two hospitals indicated that with more social service and medical staff they would be doing more home visiting or other kinds of follow-up work with patients on furlough. The social workers in all the hospitals have good liaison with the vocational rehabilitation counselor from the state Bureau of Rehabilitation. Two hospitals register selected patients with their social service exchanges and are, in turn, notified by the exchange if a furlough patient contacts a social agency. Liaison with social agencies is spotty, depending on the social service director in each hospital. Some maintain liaison with most of the agencies, either directly or through the council of community services or in professional association with other social workers. Agencies which have proved most helpful have been DPA, of course, family service, child welfare or children's aid, and community psychitaric clinics.

PHN and VNA

Contact with the public health nurse or visiting nurse association has also been spotty. Six hospitals reported having occasional cases visited by the PHN or VNA nurse, and one hospital had furloughed patients in one county it serves visited during the past year (about 25 patients were seen). At least one more hospital would like to have this kind of follow-up. The hospitals have not expressed much interest in developing this resource, although in at least one county the VNA has expressed keen interest in providing the service free to furloughed patients. One hospital superintendent said he would be willing to pay the VNA fees if his budget would allow it.

REHABILITATION

Social Clubs

A reluctance to "control" the patient once he leaves the hospital was reflected in the attitude of some hospital staffs toward social clubs for ex-patients. Two hospital superintendents and the clinic director in a third hospital were opposed to these clubs on the ground that the ex-mental patient should not fraternize with other ex-patients but should re-establish old social and community contacts such as his church, service club, etc. One superintendent felt that only "hypomanics" want such clubs. Two others who favor social clubs for some patients warned that normal social contacts were the most desirable and should be encouraged. However, seven hospitals approved of social clubs, some with reservations. Four hospitals have worked with such clubs as Fountain House in Philadelphia and Bethlehem and the Reading Friendship Club.

Vocational Rehabilitation

All of the hospitals find the work of the vocational rehabilitation counselors valuable but have reservations about the time and effort spent on individual cases. The counselors do a good job with the patients they select, the ones who indicate good work potential at skilled, white collar, or professional levels. But the great majority of furloughed patients can do only unskilled work in factories or on farms or work as domestics in homes; very little is done to locate jobs for them. Some hospitals place them on farms or as domestics in homes where they live in. But many superintendents fear that the patient will be exploited in such situations and have generally stopped placing anyone in jobs of this kind. They feel a need for suitable job placements of unskilled patients where they are also protected. This is one area where the hospitals would welcome help from mental health associations.

Halfway houses exist in conjunction with three hospitals (although they are not necessarily situated on hospital grounds) and are wanted in three more. One hospital says it tried a halfway house but gave it up because the staff decided that the patient was usually well enough to go home when he seemed well enough for a halfway house environment. Three other hospitals do not feel they could run a halfway house, because they are too isolated geographically and could not combine the family type living with work opportunities on the outside. The hospitals which have the houses indicate they are very pleased with them and consider them a definite bridge back into the community.

SUMMARY

In summary it must be noted that the hospital has almost no contact with about 75 per cent of its furloughed patients. The other 25 per cent are seen in out-patient clinics or by social service and vocational rehabilitation counselors or are contacted by letter and sent questionnaires. The hospital may feel that many of these patients are well enough to be discharged but are carried on its books the entire three years as a precaution and to make it easier for the patient to be readmitted if he has a remission. Or it may be that the hospital staff feels the patient should not be checked on too closely since it would cause resentment or might make him too dependent on the hospital. In order to facilitate his psychiatric, social, and vocational readjustment the patient needs help in a variety of ways. Superintendents and social service directors differ in what they consider the best ways, but there is sentiment in favor of having mental health associations and other community groups assist in:

1. Locating foster homes where the hospital feels such a need exists;
2. Exploring and promoting arrangements with public health and VNA nurses for follow-up of furloughed patients;
3. Gaining public support for more funds so hospitals can institute or expand out-patient clinics which would provide treatment as well as drug therapy and where drugs would be provided free; the cost to the public would be a fraction of what is now spent to provide custodial treatment to patients who could be furloughed under such conditions;
4. Promoting job opportunities for unskilled patients, especially by approaching industry in each community along the lines followed by the San Francisco MHA;
5. Stimulating interest in and support for social clubs for ex-mental patients;

6. Helping hospitals establish and furnish halfway houses and assisting in work with these patients so that they can find employment and eventually become self-supporting; a "Big Brother" role was envisioned by some hospital staff members;
7. Extending a "Big Brother" role to include helping the furloughed patient become accepted by his family, neighbors, and old social contacts, including church and clubs;
8. Planning regular orientation meetings for relatives of patients where professional staff can help develop the insight and understanding that relatives need for patients who return from the mental hospital;
9. Developing public support and funds for psychiatric clinics in the community, beds in general hospitals, orientation for family physicians, and any other facilities which would help the furloughed patient make a satisfactory adjustment.

How far hospitals and communities are prepared to go in carrying out any of the above programs may depend more on attitudes than on resources or personnel. Dr. George S. Stevenson warned in 1950 (8) that the state mental hospital, because of its remoteness from the community, tends to adapt very slowly to newer demands. He noted that:

"Progress in the mental hospital has tended to come from influences only within itself and to refine more and more the intra-institutional services to its traditional patients. It belongs to and feels for no one community because it serves many communities. Its distance from its communities has even affected its work on its traditional patients. For example, it is half a century since we came to appreciate the value of knowing the home setting of mental-hospital patients, of discharging the patient into a suitable environment, and of continued aftercare treatment (follow-up) in the community after discharge. These community responsibilities have been recognized as important to the patient in the same way as the services performed within the hospital. But these services are not today generally provided as a part of psychiatric service to a community, though they are an earlier step in the progressive growth of the hospital than service to non-hospital patients."

The hospitals and communities are beginning to work together in providing aftercare services for the ex-mental patient. The process will have to be speeded up if our patient population is to continue its downward trend.

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LAWRENCE K. FRANK

Professional schools and mental health

Every professional school operates with certain beliefs and assumptions about human nature and human behavior and also the relation of the individual to social order. For the most part, these assumptions are not recognized nor explicitly stated; nevertheless, they operate as preconceptions and assumptions to guide the training of students and later their professional work when they enter upon the practice of their profession.

Before discussing the various professional schools, it should be emphasized that sooner or later it will be necessary to set up more effective screening procedures to select, for exclusion, those individuals whose personality make-up and immaturity, despite their intellectual ability and skills, make them potentially dangerous to our society if they are permitted to engage in professional practices.

In many professions today, warped, distorted, and immature personalities are inflicting damage upon others whom they are teaching, treating, advising, etc., in their professional work. It is, therefore, important to recognize an initial or threshold task of better selection of candidates for all professional schools and to screen out those who cannot be expected to be interested in personalities and those who are not psychologically fit to be entrusted with the great power and responsibilities of a professional worker.

Looking at the situation in American universities today, we see a variety of professional schools on the same campus, under the same auspices, training students with not only different, but often with conflicting beliefs about human nature and social order, sending them out to engage in pro-

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fessional practice, to add to our already confused and conflicting society by their divergent beliefs and expectations. We cannot expect to advance mental health or the goals of an orderly society while the trained graduates of most of our professional schools are either actively opposed to the basic concepts of mental health or are indifferent or unwilling to collaborate in the immense task of achieving better mental health and a healthy social order.

A concerted program to reorient professional and graduate schools is, therefore, urgently needed today. Such a program would attempt to enlist the interest and cooperation of each of the professional societies or associations, the professional schools through their recognized associations, and especially the few individuals in each profession who are aware of what is involved. The purpose of such a program would be to stimulate and encourage each professional group to undertake its own reorientations, by providing materials and consultations and conferences that each may need. The aim of such a program is to infuse all professions with the awareness, understanding, and applicability of mental health principles in their regular professional practice, not to divert them or to convert them to psychiatric or social work activities. Only as all the professions can and will participate, can we hope to attain the goals of mental health.

It would also be highly desirable if one university in which mental health has been recognized in at least one or two professional schools would undertake a systematic exploration of the possibility of developing a consistent and integrated program of similar instruction for all its professional students in undertaking dynamic conceptions of human nature and human behavior. This will not be simple, and it will require some years of discussion and conferences by representatives of the different professional schools to clarify their thinking and to work out such a common core of orientation and its adaptation to the needs of each professional school.

No more important task in professional education could be undertaken today than such an exploration. The university which undertakes this will be making a great contribution not only to professional education but to our whole social life.

Looking at specific professional schools, we may note the following:

MEDICAL SCHOOLS, SCHOOLS OF NURSING, SCHOOLS OF SOCIAL WORK

All three of these are now providing increasing opportunities for students to gain understanding of mental health and a recognition of their role in fostering mental health through their usual professional work. All three of these schools are now training psychiatrists, psychiatric social workers, and also psychiatrically oriented nurses, to some extent.

There is no generally accepted pattern for this training nor are there enough well-trained teachers to provide the necessary instruction in these schools. What is especially needed is a clearer recognition of how the physician in the home, the clinic, and the hospital, along with the nurse and the public health nurse, can advance mental health in and through their personal as well as professional relations with all their patients as they apply their specialized knowledge and skills.

It is especially important that medical students learn more about family living, parent-child relationships, child growth and development, aging, personality development, school health needs, and how to work with social workers, teachers, and other professionals in the community.

Because of their professional responsi-

bilities for therapy, the emphasis in teaching is primarily on diagnosis and treatment of mentally ill or disturbed personalities. An understanding of how, as professionals, they can function in and through community mental health programs is urgently necessary.

DENTAL SCHOOLS

Dentists, especially those treating children, should be better oriented to children as developing personalities so that in their work they will give reassurance and avoid traumatizing their child patients. This also applies to other specialists who treat children.

LAW SCHOOLS

Lawyers serve as advisers to individuals, families, and organizations, especially business and industrial, where their advice and counsel are directly concerned with human relations, with disputes, conflicts, and industrial relations, and with marital and parent-child relations. Lawyers also serve as legislators and as judges; they make judgments and decisions of far-reaching significance for mental health upon a variety of issues, including the many forms of deviations known as crime and delinquency, divorce, etc.

For the most part, law students are trained in the familiar conception of a rational human nature, of human motivations of the older, voluntaristic beliefs, and they carry these assumptions into their legal careers where their ignorance of, resistance to, or rejection of new understanding and insights constitute one of the major obstacles to the development of mental health. As legislators, lawyers with their older assumptions and beliefs are blocking many urgently needed changes in all areas of social life, especially provisions for better care of the mentally ill and for mental health services for all areas of life.

It would be appropriate to introduce law students to dynamic conceptions of personality through courses on contracts, torts, criminal law, evidence, and domestic relations and to give them an understanding of the clinical approach which has been accepted in many juvenile courts and is now being advocated in divorce and family courts.

SCHOOLS OF EDUCATION

The school teacher is potentially the most important professionally trained individual in the development of mental health. Next to the home and parents, the school and the teachers are in the most promising position to foster mental health in the classroom through direct relations with the class as a group and with individual pupils.

Especially in adolescence, when boys and girls are often in conflict with their families, the high school teachers can be of immense help to students when they have some understanding of the problems of that age group and some insights into the relationships they have with students.

Increasingly, schools of education, including teachers' colleges, are giving courses in child development and utilizing nursery schools for observation. But student teachers are not receiving systematic training in the newer concepts of personality development and are still being taught educational psychology derived primarily from animal experiments about learning that ignores the emotional and other human aspects of learning, especially symbolic learning.

In university schools of education, where many of the leaders and administrators of school systems are being trained, failure to provide understanding of what mental health means in schools is perpetuating the

resistance to much-needed changes in classrooms and is defeating the efforts of these teachers who are trying to infuse their work with mental health understanding.

THEOLOGICAL SEMINARIES

The clergy have a close, intimate relationship to families and children; they are probably more frequently called upon for advice and guidance in times of family and personal crises than any other professional group. While a few theological seminaries are beginning to offer some orientation in mental health to their students, the majority are still teaching the older conceptions of human nature and are training students to maintain the traditional moralistic approaches to human difficulties.

The Council on Clinical Training is fostering specific training among the Protestant clergy through internship in mental hospitals and is concerned with the earlier orientation of theological students.

Again, the emphasis is upon understanding individual conflicts and personality disturbances, so that the teacher-minister may not receive much orientation to the tasks of community mental health in which he can actively participate with others.

As the churches recognize that the mental health movement is predicated upon the traditional religious belief in the worth of the personality and human dignity, including the dignity of the child, they can utilize their immense influence and their close relationships with families to foster mental health. What is perhaps as important will be the diminution of the present theological emphasis upon an evil human nature and upon creating and intensifying guilt feelings and the acute conflicts now being fostered by some of the accepted teachings of the churches.

Recently there has been a promising movement to revise the traditional Sunday school programs by recognizing the new understanding of child development and the so-called "child-centered" approach in education.

The churches are potential allies of mental health and can be more actively enlisted in the movement as the present programs of theological schools are reoriented and as ministers in service are given some reorientation, as in the publication of *Pastoral Psychology*.

SCHOOLS OF PUBLIC HEALTH

Mental health as a community-wide problem is emerging as a specific responsibility of public health. The American Public Health Association now has a section on mental health and many public health administrations are active in mental health programs However, many students of public health are not receiving the orientation and understanding needed for accepting these larger responsibilities or for infusing mental health into their present activities, such as prenatal and well baby clinics. The schools of public health are recognizing the task of health education as their professional obligation, but, for the most part, are unaware of the need for insights into the individual's beliefs and attitudes toward his or her own body and the importance of recognizing personality and emotional reactions in order to make health education effective.[1]

Because public health agencies and personnel will be increasingly involved in preventive medicine and health care, they will need further training in mental health thinking and practices.

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[1] Frank, Lawrence K., "Health Education," *American Journal of Public Health*, 36(April, 1946), 357–66.

SCHOOLS OF PUBLIC ADMINISTRATION

The development of graduate schools of public administration to train personnel for service in local, state, and national governmental organizations marks a significant trend of great promise. The graduates of these schools are being drawn into governmental service and are becoming responsible supervisors and policy makers or advisers to top executives. In these capacities they are concerned with a variety of problems that have large mental health implications, including the important question of maintaining the efficiency and morale of civil service employees and meeting the many disputes and conflicts arising in these services, such as the police force, fire departments, sanitation departments, and the employees of municipal public utilities, transportation, electric light, and water supply. The mental health of police is becoming an urgent problem in view of many disturbed policemen who act irresponsibly and often violently, including suicide.

The students of public administration are a strategic group for whom an understanding of mental health is greatly needed if they are to play their roles effectively and to help advance mental health programs in their communities, especially in cooperation with other professional agencies.

SCHOOLS OF ENGINEERING AND ARCHITECTURE

Schools of engineering and architecture are preparing personnel for professional work that has a direct bearing upon mental health objectives.

Engineers are now designing factories, machinery, technological processes, vehicles, highways, setting up industrial organizations, and increasingly determining the physical conditions under which men and women must work. Because the engineering students are primarily trained in physical sciences, mathematics and engineering techniques, plus some training in economics, they are usually ignorant of, and indifferent to, human relations and the direct impact of their professional decisions and practices upon human living. While engineering schools are increasingly offering programs in humanities, these courses are largely reading and discussion of historical material which may enlarge the student's awareness and understanding in those areas, but do not give him an awareness of his responsibility for mental health in his professional practice in the world of today.

In consequence of their narrow assumptions and practices, efforts to foster safety, health protection, industrial relations, and mental health must be carried on independently and often against formidable physical and mechanical obstacles created by the engineers who are unaware of what they are doing, or failing to do, in their professional work.

It seems clear that if engineers were given some understanding that all their factories, machines, processes, highways, vehicles, etc., were necessarily to be used by people whose feelings, behavior, and relationships were largely controlling, then the engineering profession might contribute to, rather than impede, the mental health movement.

The problem is to convince the engineering student that, in all his work, he is acting upon assumptions about human nature and social order, with expectations of what people will do and not do, that are no longer adequate, and that the insight and understanding of mental health will make it possible for him to increase the effectiveness and productivity of the things he designs and builds because they will be more nearly in accord with what we know now

about human behavior and emotional reactions.

Architects, likewise, are engaged in designing buildings for use by people—employees in factories and offices, pupils or students in schools, patients in hospitals and clinics and other institutions, and members of families in housing developments or individual homes. Few, if any, architects have had any orientation in mental health, in understanding the dynamics of family life, the requirements of homemaking today, and how in the design, equipment, and construction of buildings, many of the objectives of improved living and mental health could be greatly facilitated. This is especially important for the growing number of older persons for whom better housing is needed.

The importance of providing homes that are specifically designed to foster family living, including more adequate provision for child care and rearing, cannot be overemphasized. At present, we are exhorting families to accept the new knowledge and put into practice improved ideas of housekeeping, home management, nutrition, sanitation, safety, health care, and mental health; at the same time we expect families to accept and apply ideas in housing that not only ignore these needs but often perpetuates the older assumptions and designs that make improved living difficult, if not impossible.

Few, if any, schools of architecture now give their students any systematic instruction in family living, what it involves today, the changing functions and responsibilities of the home, especially with the wife-mother working for wages, or the dynamics of family relationships during the family life cycle. Few give any instruction in child growth and development, what homes need to provide for improved child care and rearing, and for physical and mental health. Few architects have any realization of what opportunities there are in housing developments to provide what families so urgently need to meet their greatly enlarged parental responsibilities today and to maintain some balance and sanity in the midst of the disorder and confusion in our social order.

SCHOOLS OF PLANNING

Students are now being trained for regional and urban planning, focused largely upon physical planning, with the chief concern on site planning, zoning, traffic, circulation, and the various provisions for physical operations and needs such as water supply, sanitation etc. While the planner is in a strategic position to advance mental health through his work of planning an orderly, efficient design for living in a given area, few planners are aware of their many opportunities to promote mental health through their planning.[2]

Not only can the planner seek to reduce the many unnecessary stresses, conflicts, and other burdens upon people, but he can also plan for ways of living, working, and recreating which will enable people to cope more effectively with their life tasks and to find fulfillment of their many needs and aspirations. The planner is in a position to orchestrate the many diverse activities and arrangements so that they can be oriented to a more coherent and humanly desirable way of living.

SCHOOLS OF JOURNALISM, COMMUNICATIONS, AND PUBLIC RELATIONS

Schools of journalism are engaged in training students for work on newspapers and other publications and in providing in-

[2] White, Richard, *Planning for Mental Health* (Massachusetts Institute of Technology, student thesis, 1957).

service training for working newspaper men. But, again, these students receive little or no orientation in mental health and have no systematic instruction in the new understanding of personality and human relations. Since the newspapers are the chief instruments for interpreting events, especially human conflicts and interpersonal relations, it is important that these few university trained journalists be given some understanding of what mental health means. Beyond the current practice of exposing conditions in mental institutions and whenever possible ridiculing and attacking psychiatrists, newspapers are unaware of mental health, except for a few feature writers in one or two of the large metropolitan newspapers.

The schools of journalism should be made aware of their social responsibilities in this area, of the need to give reporters and rewrite men a better understanding of what they are now doing, and failing to do, in mental health, and how they are perpetuating the archaic beliefs about human nature in their papers.

Those schools which are training personnel for work in communications through the mass media of radio and television and through public relations activities also have a large potential contribution to mental health. The frequent misleading, confusing, and sometimes highly disturbing presentations are inimical to mental health and call for change. To avoid the threat of censorship, communication workers should be made aware of what they are now doing to invite censorship and helped to understand how they can contribute to mental health through their professional work.

SCHOOLS OF HOME ECONOMICS

In every state university land grant college, also in many other colleges and universities, including teachers' colleges, and in many high schools, home economics courses are being taught with little understanding of the personality and emotional aspects of home and family living. Fortunately, a growing number of teachers are attempting to provide their students with more understanding of family dynamics and the family life cycle and are offering observations in nursery schools along with courses in child development. A systematic reorientation of all home economics courses, including those in extension services, under state and federal auspices, would make these programs more effective for mental health, improved family living, and child care and rearing.

COLLEGES OF AGRICULTURE AND FORESTRY

A considerable number of the graduates of these colleges become teachers, extension workers, and administrators of state and federal programs dealing directly with people living on farms. Their work is primarily that of re-education, persuasion, and redirection of those engaged in agriculture who today are undergoing extensive alterations in their customary practices and modes of living. Thus, they are dealing with people, many of whom are undergoing considerable tension and conflict which might be allayed if these workers had more understanding of mental health and how to deal with the frequent resistances they encounter in their work.

GRADUATE SCHOOLS OF SOCIAL AND BEHAVIOR SCIENCE

Students today are being trained as economists, political scientists, social psychologists, sociologists, and anthropologists, largely in terms of the eighteenth and early nineteenth century conceptions of human nature and conduct and of social order, which they apply later in their teaching and in their various activities as advisers, policy makers, administrators, etc.

It is indeed curious, and, in the long run, will be increasingly tragic, that many of

those who are being trained to do social research and to guide our society in meeting its many difficult social problems are operating with these obsolete conceptions of human nature, ignoring or rejecting the recently developed insights into personality and the new understanding of human behavior in economic, political, and social activities.

A few institutions are providing the students of social psychology, of sociology and anthropology, and of political science with some orientation in dynamic psychology, but it is safe to say that the bulk of the graduate work in American universities is carried on in terms of the ideas of Locke, Hume, Bentham, and those who have elaborated these earlier ideas of human nature and human behavior and of social order, with emphasis upon quantitative studies.

The consequences of this continued indoctrination of students of social science in these obsolete assumptions are far-reaching today when social scientists are playing increasingly active roles as advisers in government, in business, and indirectly in public affairs generally.

It is imperative that these graduate students be given some awareness of new ideas and of their implications for their specific disciplines and for thus enlarging activities outside the university.

Clinical psychologists are also being trained in universities chiefly in the departments of psychology which emphasize experimental studies. These clinical psychologists constitute another growing professional group whose participation in fostering mental health may be increasingly important as their training is refocused.

Recent federal legislation aims to increase the number and improve the training of individuals for work in counseling and guidance in schools, especially in high schools. These students need, in addition to the usual training in tests and measurement, more understanding and clinical experience, so that in their professional work they can further the mental health of their own students.

TEACHERS OF ART, MUSIC, DANCE, DRAMA, AND PHYSICAL EDUCATION

All of these teachers are in a position to contribute to the mental health of students when they have an awareness of how their teaching can provide individual students with much needed opportunities for the discovery of self and for finding release and fulfillment through these activities. If all these teachers had the understanding and skills which a few leaders in each area now exhibit, it would be possible to make our high schools more effective agencies for the promotion of mental health of adolescents. This does not mean making the teachers into "amateur psychiatrists" but rather helping them to discover how to use the subjects and activities they teach in ways that are more appropriate for the mental health of their students.

As the foregoing indicates, a concerted effort to enlist all the professions in the mental health movement would greatly enlarge resources for this task. Since the need is similar in all the professional schools, it would be desirable to plan a cooperative program to help all these different professions by providing the material and the assistance which each could adapt to its own special needs and requirements. This could be done by establishing a Commission on Professional Education.

Obviously no immediate results should be expected, but the fruits of such a program should begin to be cumulatively apparent in the years ahead as these various professional workers take their places in the community and begin to practice with this new orientation.

BENJAMIN MALZBERG, PH.D.

Statistics of admissions to and discharges from state schools for mental defectives

According to the Biometrics Branch of the National Institute of Mental Health, there were 129,187 patients on the books of the 97 public institutions for mental defectives in the United States at the close of fiscal year 1954 (1). Of this total, 113,960, or 88.2 per cent, were in residence. The resident population had grown by 20,000 during the previous decade. This did not result from any marked increase in admissions, because the annual admissions grew during the same period by only 2,685. The increase was caused by the excess of admissions over removals. In 1954, for example, there were 11,577 admissions to the public institutions for mental defectives (excluding transfers), 1,223 discharges from institutions, and 1,930 institutional deaths. Even with adjustments for extra-mural care, the admissions were in substantial excess. The death rate among institutionalized mental defectives has decreased in recent years. If the population of these institutions is to be reduced, or even stabilized, in number, this must come from an increase in the rate of discharge. Up to 1954, there had been a decreasing trend in such rates, however. In 1941, the public institutions had a discharge rate of 48.9 per 1,000 average patients on the books. This increased to 54.4 in 1943 but fell to 36.9 in 1954.

New York state has the longest series of statistical data with respect to movement of patients in state schools for mental defectives. There are six such schools. They date from 1855 when the Syracuse State School was opened. From the beginning,

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this school has been directed primarily to the higher grades of mental deficiency. A second state school was opened at Newark with provision for patients who were not adapted to the classroom type of instruction provided at Syracuse. In 1893, a third state school (for unteachable mental defectives) was opened at Rome.

These schools are in central New York, and provision for New York City was inadequate. A fourth state school, Letchworth Village, was therefore opened in 1911 and received patients from New York City. The growth of the general population resulted ultimately in overcrowding of the state schools. It became necessary to erect an additional school. The site chosen is in Dutchess County where the Wassaic State School was opened to patients in 1931. Further growth of population again made it necessary to build a new school. The new site is on Staten Island where the Willowbrook State School was opened in 1948.

These six schools are administered centrally by the New York State Department of Mental Hygiene. Three schools are relatively close to New York City. The other three serve the remainder of the state. Syracuse State School limits admissions to the higher grades of mental defect. Willowbrook gives special consideration to very young and low-grade defectives. The other schools accept defectives of all grades.

The need for expansion continues, however, and a new school is under construction in the western part of the state, near Buffalo. The other end of the state will benefit from the construction of a new school in Suffolk County. An additional school will be constructed in Brooklyn to care for defectives who are severe behavior problems in the other schools.

The existing schools had 24,148 patients on the books in March, 1958. Estimates of the prevalence of mental deficiency vary, but if we accept the statement that approximately two per cent of the population of school age is defective, this implies that there are about 85,000 defectives in this age group in New York state. If one per cent of the total population is defective, this implies that there are about 170,000 defectives in the state. If only half of these need specialized care, we have a total of 85,000 defectives, compared with only 24,000 under treatment currently. If we limit the estimate to the child population, and assume that half of the defectives in this age group require institutionalization, this would still be twice the actual population of the state schools. Admission to the schools must, therefore, be selective and limited largely to those in urgent need. Therefore, the population of the state schools is not a random selection of all defectives. There are differences with respect to age and sex distributions, and the younger undoubtedly include a higher proportion of imbeciles and idiots. This selection influences rates of mortality (2) and will also be shown to have an important effect upon rates of discharge.

Table one provides a summary of the number of patients on the books of the New York state schools for mental defectives from 1930 to 1958. The population grew from 9,046 in 1930 to 18,144 in 1942. It fell, during the war, to 17,971 in 1944 but has since risen to 24,148. The sex proportion of the book population has varied. Prior to 1946, females were generally in excess, but males have been more numerous subsequently.

The rate per 100,000 population grew to 144.6 in 1945 but declined to 131.1 in 1948. The rate grew to 146.4 in 1956 and to 145.2 in 1958. Since 1936, the male rate has exceeded that for females.

Table two provides a summary of the

TABLE 1

Number of patients on the books of New York state schools for mental defectives

YEAR *	NUMBER			RATE PER 100,000 POPULATION		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*
1930	4,293	4,753	9,046	67.9	75.6	71.7
1932	5,285	5,653	10,938	82.6	88.4	85.5
1934	6,359	6,568	12,927	98.2	101.1	99.7
1936	7,348	7,391	14,739	112.2	112.0	112.1
1938	8,187	8,063	16,250	123.6	120.4	122.0
1940	8,835	8,663	17,498	131.9	127.4	129.6
1942	9,107	9,037	18,144	143.4	133.0	138.0
1944	8,904	9,067	17,971	145.7	138.5	142.0
1946	9,127	9,177	18,304	142.0	136.6	137.4
1948	9,426	9,330	18,756	136.4	126.1	131.1
1950	10,238	9,853	20,091	143.0	128.4	135.4
1952	10,886	10,250	21,136	148.2	130.3	138.9
1954	11,727	10,712	22,439	154.7	132.0	142.9
1956	12,540	11,135	23,675	160.7	133.2	146.4
1958	12,820	11,328	24,148	159.6	131.7	145.2

* June 30 through 1942; March 31, thereafter.

resident population, which includes those in colonies and in family care. The resident population represents, currently, approximately 97 per cent of the book population. The growth of the resident population is caused, in part, by a decrease in convalescent care. Except for a decrease in 1944, the resident population has increased steadily to a maximum of 22,581 in March, 1958. The introduction of tranquilizing drugs in recent years slowed the rate of growth but did not cause a decrease in the resident population. Since 1935, the rate per 100,000 population has been higher for males than for females.

FIRST ADMISSIONS

Despite the growth of population, there has been no correspondingly great increase in the number of first admissions. Such admissions depend, in large part, upon increases in capacity. Thus, there was a marked increase in 1932 following the opening of Wassaic State School. However, this was followed by a decreasing trend through 1944. The number of first admissions has since risen, caused, in part, by the opening of Willowbrook State School. Male first admissions exceed females primarily because of behavior problems which make it more urgent to admit males.

The rate of first admissions per 100,000 population rose rapidly between 1928 and 1933, but this was followed, from 1933 to 1944, by a significant decrease. The rate rose slowly between 1944 and 1954 although it remained far below the maximum, which was reached in 1933. The rate has been

declining again since 1954. Throughout the years, the rate per 100,000 males has exceeded that for females.

Significant changes have occurred among first admissions with respect to the relative distribution of the levels of intelligence. The percentage of idiots showed a downward trend between 1930 and 1940 but has since increased steadily to a maximum of 22.3 in 1956. Imbeciles, too, showed a rising trend almost without interruption between 1930 and 1956. Corresponding to these increases, there was a reverse trend for the morons. This group constituted 56.3 per cent of all first admissions in 1930, but the percentage fell, with minor fluctuations, to 38.9 in 1956.

The increase in defectives of low intelligence cannot be imputed to an increase in their numbers among the unselected population of mental defectives. The change in trend must be attributed to growing social pressure to admit very young defectives to the state schools. Idiots, especially, form a large part of the admissions of this age group.

The pressure for the admission of the very young was first noted in 1946. In that year, first admissions aged less than five years included 8.5 per cent of the total first admissions. This percentage grew year by year, reaching 26.0 in 1954. The percentage fell slightly to 24.3 in 1956, still well above that of the previous decade.

DISCHARGES

The rate of discharge per 1,000 patients under treatment has varied significantly since 1930. It declined between 1930 and 1940, then increased through 1944. This was associated with circumstances during World War II when it was possible to find

TABLE 2

Number of resident patients in New York state schools for mental defectives

YEAR *	NUMBER			RATE PER 100,000 POPULATION		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*
1930	3,853	4,159	8,012	60.9	66.1	63.5
1932	4,890	5,103	9,993	76.4	79.8	78.1
1934	5,846	5,932	11,778	90.3	91.4	90.8
1936	6,606	6,580	13,186	100.9	99.8	100.3
1938	7,343	7,248	14,591	110.9	108.2	109.5
1940	7,852	7,740	15,592	117.2	113.8	115.4
1942	7,993	7,915	15,908	125.9	116.4	121.0
1944	7,998	8,039	16,037	130.9	122.8	126.7
1946	8,299	8,156	16,455	129.1	118.4	123.6
1948	8,711	8,472	17,183	126.1	114.5	120.1
1950	9,602	9,081	18,683	134.1	118.4	126.0
1952	10,249	9,414	19,663	139.4	119.7	129.2
1954	11,140	9,970	21,110	147.0	122.9	134.6
1956	11,795	10,340	22,135	151.1	123.7	137.0
1958	12,053	10,528	22,581	150.0	122.4	135.7

* June 30 through 1942; March 31, thereafter.

TABLE 3

First admissions to New York state schools for mental defectives

FISCAL YEAR	NUMBER			AVERAGE ANNUAL RATE PER 100,000 POPULATION [1]		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*
1930	577	623	1,200	8.8	8.1	8.4
1932	1,005	939	1,944	13.8	12.1	12.9
1934	871	774	1,645	14.9	12.8	13.8
1936	869	788	1,657	14.6	12.4	13.5
1938	933	769	1,702	13.8	11.4	12.6
1940	768	627	1,395	12.3	9.6	10.9
1942	762	614	1,376	11.7	9.3	10.4
1944	700	500	1,200	10.9	8.4	9.6
1946	764	522	1,286	11.5	8.3	9.9
1948	705	586	1,291	10.9	8.3	9.6
1950	868	634	1,502	11.7	8.4	10.1
1952	819	684	1,503	11.6	8.7	10.1
1954	911	748	1,659	11.9	8.9	10.3
1956	938	674	1,612	11.9	8.5	10.1

[1] Based upon average number of first admissions during 3 consecutive years, i.e., rate for 1930 is average for 1929–1931, inclusive.

employment, especially for males, thus permitting the discharge of an increased number of patients. Since the end of the war, both the number and rate of discharge have declined steadily. The trends are strikingly similar for males and females although the rate for males is consistently higher than that for females.

Rates of discharge are available since 1940 in relation to mental status. Rates for idiots are understandably low and ranged, during this period, from a minimum of 7.3 per 1,000 under treatment to a maximum of 9.4. Because of the small number of discharges, the rates fluctuated abruptly within these extremes. Nevertheless, rates for males were significantly higher than those for females.

The rate of discharge rose significantly higher among imbeciles, varying from a minimum of 16.1 to a maximum of 30.9. The rate rose to the maximum in 1944 and has since dropped steadily to a minimum in 1954. The maximum rate of discharge occurred during the war years. There was a great similarity in trends for males and females although rates for the former were in significant excess throughout.

A further increase in rates of discharge occurred among morons. These fluctuated between 62.1 and 118.1. The rates rose to a maximum in 1943 and 1944 and declined steadily, except for a minor rise between 1950 and 1952, to a minimum in 1955. The male rates exceeded those for females up to 1951. In recent years, females have had higher discharge rates than males.

The downward trend in discharges is, in itself, a contributing factor to the continuation of the trend. Those who continue in residence have a lesser probability of subsequent discharge, since the rate of discharge

is related inversely to the duration of residence.

Rates of discharge, when based upon the total under treatment during the year, tend to be underestimated, because the latter total is weighted with patients with long periods of prior duration of residence. The most accurate measure is obtained by computing the duration of residence from the date of first admission to the date of discharge. This method (cohort analysis) was applied in a study of discharges among first admissions to the Pacific State Hospital in California during the period 1948–1952 (3). There were 722 first admissions during this period.

The most significant findings were as follows: Of the 722 first admissions, 13.9 per cent were discharged within a year after admission. During the entire period of observation (four years), 36.8 per cent were discharged. The discharges decreased with the flow of time, only 5.6 per cent being discharged during the fourth year, compared with 13.9 per cent during the first year. There were some sex differences although they do not appear significant. Thus, 14.7 per cent of the males were discharged within a year, compared with 12.7 per cent of the females. During the four years, more females were discharged, however, the percentages being 38.2 for females and 35.8 for males.

The probability of discharge (per 1,000) varied directly with age at first admission. During the first year of hospitalization, they rose from 0.031 among those aged 0–4 years to 0.287 among those aged 16–17. The probabilities of discharge decreased as the duration of hospitalization increased. For example, for all patients, the probability decreased from 0.139 during the first year to 0.096 during the fourth year. Within each period, however, the probability of release

TABLE 4

Distribution of first admissions to the New York state schools for mental deficiencies, in per cent,[2] according to mental status

FISCAL YEAR	IDIOT	IMBECILE	MORON
1930	11.6	25.2	56.3
1932	13.9	27.3	53.1
1934	10.5	27.1	54.4
1936	10.3	31.6	53.3
1938	10.3	30.2	51.9
1940	9.3	30.8	51.1
1942	9.7	32.3	52.9
1944	12.4	30.3	56.1
1946	13.4	32.8	51.8
1948	15.9	34.1	48.3
1950	16.9	38.8	43.3
1952	18.0	39.6	41.4
1954	20.8	40.1	38.2
1956	22.3	37.5	38.9

[2] See footnote to Table 3.

TABLE 5

Average annual discharge rate per 1,000 patients under treatment in New York state schools for mental defectives, classified according to mental status

FISCAL YEAR	TOTAL			IDIOT			IMBECILE			MORON		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
1930	77.4	56.5	66.7	•	•	•	•	•	•	•	•	•
1932	62.3	52.0	57.1	•	•	•	•	•	•	•	•	•
1934	67.7	57.8	62.8	•	•	•	•	•	•	•	•	•
1936	68.3	54.4	61.4	•	•	•	•	•	•	•	•	•
1938	61.0	52.1	56.6	•	•	•	•	•	•	•	•	•
1940	59.7	43.6	51.8	8.9	5.6	7.3	24.4	21.6	23.1	107.3	71.9	89.4
1942	74.4	52.8	63.7	9.8	6.0	8.0	31.8	25.8	28.9	138.3	90.2	113.7
1944	76.4	52.9	64.7	10.5	8.1	9.4	35.8	24.9	30.6	144.0	93.0	117.6
1946	66.2	51.5	59.6	10.3	5.5	8.0	31.4	22.7	27.2	131.1	97.2	113.6
1948	51.9	47.6	49.8	8.8	6.7	7.7	27.4	23.4	25.4	102.7	91.4	97.0
1950	39.7	38.3	39.0	9.0	7.2	8.2	22.9	19.8	21.4	76.4	75.3	75.9
1952	39.7	38.6	39.2	8.8	5.9	7.4	20.9	17.8	19.4	82.7	82.9	82.8
1954	32.6	34.0	33.3	7.3	6.1	6.8	16.9	15.6	16.2	71.2	76.6	73.8
1956	32.6	31.3	32.0	9.6	7.7	8.7	17.9	15.7	16.9	65.6	63.8	64.7

• Data not available.

increased with advancing age at admission. During the second year, the probability rose from 0.031 at ages 0–4 to 0.354 at ages 16–17. During the fourth year, they rose from 0.050 to a maximum of 0.163.

These probabilities vary with the intelligence quotient, which is equivalent to stating that they vary with mental status. They were lowest among idiots (I.Q. 0–19). For this group, the probability of release was 0.048 during the first year, with a decrease to 0.015 during the fourth year. The probabilities rose among those with I.Q. 20–49 (imbeciles) and rose still higher among morons. Those with I.Q. 50–69 had a probability of discharge of 0.227 during the first year, which declined to 0.194 during the fourth year. Those with I.Q. of 70 and over had the highest probability of discharge. It was .98 during the first year and 0.238 during the fourth year.

As the range of I.Q. varies with the clinical classification, one would expect the latter to show variations of discharge rates. Thus, the clinically undifferentiated group, which includes a high proportion of morons, had a probability of discharge of 0.196 during the first year. This rose to 0.228 among the familial group. On the other hand, groups with high proportions of low I.Q's had low probabilities of discharge. Among mongols, it was 0.048 during the first year. Among cases resulting from trauma, the probability was 0.075. Among those resulting from infection, it was 0.056.

SUMMARY

1. The number of first admissions depends primarily upon the capacity of the state schools. In 1932, the number of such admissions increased in New York state to a total of 1944, because of the opening of Wassaic State School. Admissions decreased thereafter until 1950. The opening of Willowbrook State School permitted a rise in first admissions to over 1,600.

2. Because of selection of patients, there has been a significant increase in recent years of the relative proportions of very young first admissions of low mental status to the New York state schools.

3. The resident population of these schools has almost tripled since 1930. The increase primarily is the result of the excess of admissions over removals.

4. In general, the rate of discharge has declined since 1930. An exception occurred in 1944. At that time, the war created a demand for labor, so that it was possible to find employment for many patients, thus permitting discharge.

5. Rates of discharge vary with mental status. They are lowest among idiots, intermediate among imbeciles, and highest among morons.

6. Studies of discharge rates by cohort analysis give more accurate results. They show that 13.9 per cent of first admissions were discharged within a year after hospitalization and that 36.8 per cent were discharged within four years.

7. The rates of discharge decreased as the period of hospitalization lengthened.

8. The rates of discharge varied with age at first admission, being lowest for the youngest groups.

9. The rates of discharge vary directly with I.Q. at time of admission.

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HERBERT DORKEN, PH.D.

Minnesota's progressive community mental health services

Based on the Community Mental Health Services Act of 1957 (1), which has been classed as model legislation and recommended to the Council of State Governments, a varied, challenging, and responsible program in the field of community mental health has been set into operation in Minnesota. Its early development has been previously described (2). The following is an account of the principles on which this program is based, the services offered, and the progress since its inception.

UNDERLYING PRINCIPLES

1. *The program is permissive.* A community may take advantage of state support and consultative services but is not under any obligation to do so. The initiative, then, rests with the community.
2. *Comprehensive planning.* All local agencies having a concern with mental health participate in the planning of a comprehensive community mental health service. The goal is a network of services within each community. Each center is staffed by a highly qualified professional team comprised of psychiatrist, psychologist and social worker.
3. *Local control with state support.* While each center must meet certain standards in terms of professional qualifications, range of program, accounting, etc., the planning proceeds at a local level, and the operating responsibility and administration rests with the participating communities.
4. *Matching grants-in-aid.* Up to one-half the costs involved may be reimbursable by the state to a maximum of $.50 per capita. Local financial support for most centers is derived from general county tax revenue. Where this is insufficient, there is provision for a special levy for community mental health. Private and voluntary public donations (Community Chest) are en-

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couraged. Local fee schedules may be established within certain limits (3). The minimum population base is ordinarily 50,000 for each center, the current range being 50,000 to 140,000, with an average of 80,000.

5. *Social orientation.* While direct clinical or outpatient services are provided at all centers, other important foci of attention are consultation, information, and educational services to lay and professional groups, collaboration with other agencies, promotion and development of additional community resources for mental health, training, and even research. The preventive aspect of the program and the effort to achieve full coordination and utilization of all community resources, in a continuous and comprehensive manner, gives each program a broad social base.

Typically, several counties collaborate in supporting a program tailor-made to their particular needs. The flexibility of the program is particularly evident here in the variation of services provided at the different centers throughout the state. The open-ended nature of the clinical contacts, the new and somewhat broader and more responsible level of professional service, the emphasis on community as distinct from clinical services, the relatively greater professional freedom possible in non-civil service situations, the opportunity to develop an exemplary service, the encouragement offered all professional staff to undertake private practice, the maintenance of high professional standards, and the realistic and competitive salaries offered have drawn considerable professional interest in this program. It has been possible to fill all vacancies in all professions within the first year of operation of each center and, more important, personnel turnover is almost nonexistent.

BROAD RANGE OF SERVICES

1. Collaborative and cooperative services with public health and other groups for programs of prevention of emotional and mental disorders;
2. Informational and educational services to the public, lay, and professional groups;
3. Consultative services to schools, courts, welfare, health, correctional, rehabilitation, and other agencies;
4. In-service training programs for general practitioners, teachers, nurses, clergymen, caseworkers and others;
5. Serve as a focus of mental health activities within the community and, through in-service training, demonstration and other means, promote and further the development of existing and additional mental health and related resources throughout the area served (e.g. school psychologists).
6. Outpatient diagnostic and treatment services;
7. Rehabilitative services, particularly for patients discharged from state institutions;
8. Participation in monthly statistical reporting, in research projects and surveys; and
9. Other less typical but no less important functions such as mental health consultation in industry, the establishment of a regional mental health reference library, etc.

Because of the broad range of services provided with an emphasis on the community in addition to the more traditional clinical services, we refer to these facilities as mental health centers rather than clinics.

Administrative responsibility for the policies at each center rests with a nine-member mental health board selected under the terms of the law to represent nine specific areas of interest within the community. At the staff or professional level, the day-to-day operation of the center is in the charge of a program director appointed by the board. The director is selected for his administrative experience or talent and may be either the psychiatrist, psychologist, or social worker. Medical responsibility is seen as a distinct concern which must be assumed by the psychiatrist.

The current biennial appropriation from the state legislature of $770,000 ($342,000 in the first, 1957–59, biennium of the program) now fully committed, has enabled the establishment of comprehensive mental health services which embrace 48 counties (87 within state) and are directly available in the community for some 42 per cent of the state's three and one-half million population. Prior to the passage of the act in 1957, the state maintained two all-purpose mental hygiene clinics, a follow-up clinic, and an alcoholism clinic. In addition, there were four private agencies which provided out-patient mental health services. (The follow-up clinic closed June 30, 1960, and the alcoholism clinic will be reintegrated with the state hospital program thus bringing to an end in Minnesota the era of the state-operated clinic.) Since the passage of the Act, three of the private agencies have received grants to add to staff, while the fourth (Duluth), has expanded its program through matching state grants-in-aid. The two all-purpose mental hygiene clinics (Albert Lea and Fergus Falls) have converted to community mental health centers and are no longer under state operation. During the first biennium, that is 1957 to 1959, three new centers were established (Crookston, Willmar and Austin) and one former center reopened (Rochester), and then in July, 1959, grants were made to four more centers (St. Cloud, Grand Rapids, Marshall, and Luverne) to begin operation. Since then, applications from two additional groups (Owatonna and Bemidji) have been approved, and these became active in April and May, 1960. Several other applications are pending, and more than a dozen additional counties have demonstrated active interest. A total of $504,000 in grants and operating costs has been approved for 1960–61, with grants to county-supported centers ranging from $23,000 to $60,000 (average, $32,000).

Thus, in less than three years, it has been possible to expand or establish and staff services at no less than 16 centers throughout the state. To really measure this accomplishment, it must be pointed out that Minnesota is largely comprised of rural communities, and this poses special problems in developing comprehensive programs and recruiting qualified personnel. On the basis of strong legislative and wide public support and on the increasing demand for additional services and centers, the only possible prediction is further progress.

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Book Reviews

EARLY EDUCATION OF THE MENTALLY RETARDED

By Samuel A. Kirk

Urbana, Ill., University of Illinois Press, 1958. 216 pp.

The age-old battle of heredity versus environment, or nature versus nurture, continues unabated, in spite of many protestations about the futility of this conflict. Philosophically, one can hover above the battle, and remain aloof from it. When confronted with live issues and living children, however, one cannot remain aloof; burning questions urgently press for valid answers, and these must somehow be obtained even if basic theoretical problems have not as yet been satisfactorily solved.

In *Early Education of the Mentally Retarded,* Kirk and his associates at the Institute for Research on Exceptional Children at the University of Illinois not only raise these questions but come to grips with some fundamental issues related to the growth, development and education of young educable mentally retarded children (as against "trainable," or lower level mentally retarded). Kirk is disturbed by some existing practices and beliefs connected with the education of mentally retarded children. They are frequently admitted to regular schools at age five or six and, when unable to function normally, are discharged and re-admitted several years later in the hope that maturation will occur; or they may be permitted to fail for several years, kept with younger children, and later admitted to special classes. Special classes frequently do not exist in the first years of school. Kirk also questions the common belief that a child cannot function beyond a predetermined level established by a properly obtained intelligence test score, and raises the issue of home versus foster home or institution for some children.

Early Education of the Mentally Retarded is a report of a five-year study with 81 educable mentally retarded children between the ages of three and six. These were divided into four groups: a community experimental group of 28, an institution experimental group of 15, and a "contrast" group for each of these. Individual psychological examinations were administered at the outset and at regular intervals thereafter; social and adjustment data were collected periodically. The experimental community group attended a preschool, while the contrast group did not; the experimental institution group attended a preschool in the institution, while that contrast group did not. All were re-tested and followed up at the same intervals.

Of the 43 experimental children, 70% showed acceleration in rate of growth considerably above the expected rate, and I.Q.'s as well as social quotients showed significant increases over those of the contrast groups. Even children with organic defects showed gains, though not as great as those of the other experimental children. The reader is given the impression throughout much of the book that preschool experience raises the level of functioning of mentally retarded children, until he is startled to find that the community contrast group, which began schooling at age six, did almost as well as the experimental group. This is explained on the basis of quality of home. The final conclusion, implied, seems to be that the adequacy of the home has more influence on the rate of mental growth and social adjustment than early schooling; in the case of an adequate home early schooling does not seem necessary; in an inadequate home, such schooling is essential,

or the retarded child will develop at a much slower rate.

In the case of institution children, the conclusion is drawn that six to eight hours of daily schooling and stimulation will result in early parole from the institution, with consequent saving to the individual and to the community.

Early Education of the Mentally Retarded is an important study in a field where adequate studies are not too common, and points the way to further needed research. Although it does not clearly indicate the influence of early education on later development, it does conclude that we should reconsider our belief that "a poor home or a poor mother is better than no home or no mother" for mentally retarded children.—MORRIS KRUGMAN, PH.D., New York City Board of Education.

WHY MARRIAGES GO WRONG

By James H. S. Bossard
and Eleanor Stoker Boll

New York, Ronald Press, 1958. 218 pp.

A more exact title for this readable book would be, "Why Marriages Go Wrong in the United States." At the outset, the two social scientist authors, James H. S. Bossard and Eleanor Stoker Boll, present statistics to prove that marriages do go wrong more frequently in our country than in any other country. One example from many is that approximately one half of all the divorces reported in the world each year are granted in the United States.

Why does this tragic situation exist? In order to answer this question, the authors turn a searchlight on our society. By focusing on the social factors to the exclusion of the personal factors, they have made a significant contribution, from a sociological perspective, to the better understanding of marriage failures in our culture. Their conclusions are based on various sociological surveys and years of experience in marriage counseling.

Clearly and convincingly, they show that certain social factors in our American culture are definite hazards to marriage. Our prevailing values and standards of social behavior run counter to the fundamental principles of family life. For instance, individual development and social aggressiveness are held in high esteem while family life and family virtues are held in relatively low esteem. Our open class social system rewards individual enterprise. It is not uncommon for one member of a family to move up in the social scale, leaving other members on a lower socio-economic level. This situation is additionally complicated by the fact that national origin status also influences class level status. Above all, there is a lack of frank recognition of class status as such in the United States.

The intermingling of peoples of diverse cultures inevitably results in many mixed marriages. When young people are given free choice in mate selection, emphasis on romance tends to overshadow all other considerations. As a consequence, a married couple may have different religious beliefs, different cultural values, and different patterns of social behavior. It is these differences between peoples that causes so much friction in marriage, the authors claim; but they give little emphasis to the underlying feelings about these differences.

One of the solutions they propose is that 'like' should marry 'like'. How would such marriages be possible today, even if young people so desired, since our melting pot process has been mixing peoples of different cultures for generations? But no one would quarrel with the recommendation that Americans must give more recognition to values and value judgments, and that we should become more family-centered and less individually centered.

Although only one side of the marriage

problem in the United States is given here, it is the much needed broad sociological perspective which is overlooked by some mental hygienists and marriage counselors who have been preoccupied with the other side of the coin, the personal or intrapsychic factors. Hence, *Why Marriages Go Wrong* should be of interest to a wider public than that for whom this book was written, people directly involved in marriage.—MIRA TALBOT, Ph.D., New York City Board of Education.

ECONOMICS OF MENTAL ILLNESS

By Rashi Fein

New York, Basic Books, 1958. 164 pp.

This is a valuable book on the financial statistics of mental hospitals, and it goes beyond the intricacies of expenditures and accounting into basic questions where social policy transcends economics. The over-all annual costs of mental illness are estimated to be at least $3 billion a year. The bulk of the direct costs derives from the cost of our mental hospitals.

It is estimated that we pay privately practicing psychiatrists a total of about $100 million a year. A sum which is difficult to estimate, but which may be as large if not larger, is spent for that part of the services of general practitioners, internists and other physicians which goes to patients with mental illness.

The author makes the significant distinction between direct and indirect costs. The direct costs are the actual current outlays which are predominantly for hospital care and which total at least 1.7 billion. The book renders a service in pointing out the inadequacies of financial reporting by the hospitals. The indirect costs, as large or almost as large, are the lost earnings of the men and women who are income consumers while hospitalized, instead of being income producers and tax payers. The lost earnings often extend over many years.

It is to be regretted that there is not more comment on the differences in hospital costs among the states. Even allowing for all divergences of accounting, it is well known that certain states have greatly improved the services in at least some of their mental hospitals. Something might well have been said about the comparative costs of top notch public hospitals and those of average or below-average standards.

The present expenditures for mental illness are so large that society must ask what it is getting for its money. The question could not be answered as such, says the author, without impracticable research. Can we reduce costs, he inquires, by spending less money, or by spending more money? Adding to direct costs—chiefly by increasing the psychiatrists, nurses and attendants in mental hospitals, and by ambulatory service outside—might actually save a larger sum in the indirect costs, through earlier discharges and in other ways. Mr. Fein points out the complex factors which research would have to evaluate before a reliable estimate of quantitative savings could be made, but he remarks that if we took the other tack and deliberately spent less for hospitalization now, our society would nevertheless bear the costs of mental illness in indirect and often painful ways. Humanitarian, political and economic considerations are essentially mingled in such matters.—MICHAEL M. DAVIS, Chevy Chase, Md.

MUSIK IN DER MEDIZIN BEITRAGE ZUR MUSIKTHERAPIE

By H. R. Teirich, Dr.Med.

Stuttgart, Germany, Gustav Fischer Verlag, 1958. 207 pp.

In 18 highly diversified articles and essays, this book surveys the psychological and

physiological effects of music and their applications in medicine. Only seven articles —four of which are by American authors —deal directly with methods and experimental data of music therapy as practiced in Europe and the United States. In Europe, the approach seems more cautious and sophisticated, due, no doubt, to an older, more integrated musical culture. Several authors, though contributing original studies, particularly on physiologic reactions to music, hesitate to admit the existence of a valid music therapy whose methods can be scientifically determined, or whose applications can be controlled, like the dosage of a drug.

Several articles stand out. In "Psychosomatic Thoughts about Music," Dr. Berthold Stokvis gives a concise definition of musico-somatic phenomena, and includes the results of his psycho-physiological experiments at the University of Leiden, showing psycho-galvanograms and photoplethysmograms during musical auditions, and variations due to personality structure. Dr. Wolfgang Tränkle, in a brilliant essay, "The Stimulating and Relaxing Effect of Music," describes his "electro-myographic method" which measures the effect of music on muscle-tonus and records muscle-action currents. Dr. Tränkle's thoughtful investigation includes astute observations of the socio-cultural factors which contribute to—or prevent—the success of music therapy. Dr. Rudolf Dreikurs, of Chicago, in a brief but cogent article, "Music Therapy with Psychotic Children," summarizes his methods, techniques and successes with schizophrenic and emotionally disturbed children.

From the field of the pedagogy, care and treatment of sub-normal, retarded or handicapped children, we have a report by Dr. Karl König, of the Camphill-Rudolf Steiner Schools, Aberdeenshire, Scotland. Dr. König describes an unorthodox music therapy, based on the theories of the founder of "anthroposophy," Dr. Rudolf Steiner. Finally, Dr. H. R. Teirich, in "Music in the Framework of a Psychiatric Praxis," describes his highly individual techniques of using music in conjunction with "autogene training" and as an adjunct to group therapy and group psychotherapy. Dr. I. H. Schultz, the originator of "autogene training," also contributes an interesting article, concerned primarily with the beneficial effects of his method on the personality structure of musicians.

Music in Medicine makes valuable contributions toward a deeper understanding of the problems of music therapy, particularly in the light of European cultural conditions.—CHARLOTTE H. COHRSSEN, M.D., Essex County Hospital, Cedar Grove, N. J.

A CLASSIFIED BIBLIOGRAPHY OF GERONTOLOGY AND GERIATRICS, Supplement 1, 1949–1955

By Nathan W. Shock, Ph.D.

Stanford, Cal., Stanford University Press, 1957. 525 pp.

The student or worker in the field of gerontology and geriatrics who had heretofore to engage in exhaustive research and study, has now within his reach an extensive and comprehensive bibliography, ***A Classified Bibliography of Gerontology and Geriatrics,*** by Dr. Nathan W. Shock.

In essaying this herculean task the author has produced a prodigious work of inestimable value. And as the field of gerontology and geriatrics widens and expands, the worth of this volume will increase in like proportion, focusing the attention of the population on the ever-increasing problems of the aging and the challenge which is ours,

to meet adequately their varying needs in the complexities of the modern world.

The vast amount of material provided by Dr. Shock has been classified and put in appropriate categories and reflects the painstaking effort and care the author has gone to in compiling this work. The volume provides over 18,000 references, also contains indices of authors and subjects, and is a valuable addition to any library. Dr. Shock is to be congratulated on the comprehensiveness of this work.—MOTHER M. BERNADETTE DE LOURDES, O. Carm., Mary Manning Walsh Home, New York.

CRIME AND JUVENILE DELINQUENCY, A Rational Approach to Penal Problems

By Sol Rubin

Published for National Probation and Parole Association

New York, Oceana Publications, 1958. 240 pp.

Mr. Rubin's book is a mature, thoughtful and well documented discussion of problems that too often are shrouded in idiosyncratic hypotheses or clouded by emotionalism. It fully justifies its sub-title, A Rational Approach to Penal Problems.

The book will be of interest and value to anyone who takes an intelligent interest in the problems of modern society. For the professional criminologist and penologist, it has an unusual flavor in that it reflects the author's legal background without involving the reader in a legalistic approach.

Most of the propositions advanced are carefully reasoned and stand on their own merits.

Not everyone will agree with everything that Mr. Rubin supports. This reviewer, for example, would be inclined to give a much more negatively critical account of the Youth Correction Authority movement. Others will doubtless find other points at which they would have preferred that Mr. Rubin support their own predilections. This makes it a worthwhile book.—F. LOVELL BIXBY, New Jersey Division of Correction and Control.

BEHAVIOR AND PHYSIQUE: AN INTRODUCTION TO PRACTICAL AND APPLIED SOMATOMETRY

By R. W. Parnell

London, Edward Arnold, Ltd., 1958, 134 pp.

Can a carefully worded, sternly objective, precisely documented scientific text on body build and body-in-action excite a modern mind habituated to critical and logical thinking—not even to mention the possibility of enthusing the heart inevitably associated in a life continuum with the same mind? The volume by R. W. Parnell on "Behavior and Physique" does exactly this to the reader. Distributed by the Williams and Wilkins Co., Baltimore, exclusive U. S. agents, this small but complex book is a must in all psychiatric and related libraries. The study invokes the shades of constitutionalists such as Pythagoras, Alcmeon, Hippocrates, and others down to the present day. It extends and strengthens the work of such modern constitutionalists as Kretschmer, Pende, Viola, Bichat, Naccarati, Draper, and Tanner. It resurrects the calipers of Davenport and widens the angles of Sheldon's fundamental photographics. It underscores the work of Rees and Eysenck and adds significance to the monumental studies of the Gluecks. In short, Parnell's studies stirred both the mind and the heart of the reviewer by the realization that the constitutionalists are on the way to long-deserved recognition as the primary organizers of psychiatric study, treat-

ment, and philosophy pertaining to organogenic orientations to human behavior. Around the constitutionalists the geneticists, biochemists, and neurophysiologists can find the focusing and channeling of their laboratory activities. Upon the work of the constitutionalists, the House of Freud, of Adler, and of Jung can find that bedrock which each of these masters proclaimed to exist and upon the assumption of which they built their mansions for all mankind.

The details of Parnell's book, their correlations, agreements, dissimilarities, etc., with those of the other workers in the vineyard are too numerous for careful review here. In fact, a commentary could be written in this direction. Thus, this brief review is largely a comment on the significance of Parnell's work. A few additional notations, however, may be made.

Like the work of the Gluecks, Parnell's approach reflects possibly the best technique available today. The documentation is impressive. New potentials for the somatotyping, or rather the phenotyping, of children are presented, and fascinating roadways have been opened for the study of family differentials as to the variety of human matings, physical dominance (husbands and wives), family size, sex ratios, etc.

More repletely than ever before, significant correlations have been derived with respect to physical prowess, traits in childhood, backward-readers, and maladjustment. The technique provides new resources with respect to the study of performance in secondary school and academic life, even to the prediction of factors affecting choice of, or suitability for, specific professional activities.

If anyone doubts that mental ill-health has little in common with constitutional factors, he should reread Sheldon and the Gluecks, and carefully study Parnell's findings. It is hoped that the ensuing hieroglyphic silhouettes on body-build in relation to mental ill-health will induce readers to explore Dr. Parnell's studies:

F = Fat; M = Muscle; L = Linearity; capitals indicate dominance.

Lf types: disposed to breakdown under the age of twenty-five. *Lf* + *Fl* (women) + *Lm* (Men) found in large proportion of younger schizophrenes. Youngest males with depressions, anxiety state, psychopathy and suicidal trends concentrate here. Stabilization tends to occur later.

Lm types: disposed to breakdown from 25 to 34 years. Paranoid schizophrenia a little more common.

Ml types: disposed to breakdown 35 years and onward. Paranoid schizophrenia and primary paranoid illness commonest thought disorders. Depression major affective illness.

Mf types: most stable group. Affective disorder with depression much commoner.

F types: both men and women show diphasing. Curve of age incidence—one early in life (Fl), another after 40 (Fm). Schizophrenia occurs in Fl men and women, primary paranoid disorders in older people in Fm. Depression is common affective illness, anxiety states rare.

There is close agreement with the findings of Wittman, Sheldon, and Katz with regard to schizophrenia, especially hebephrenic forms. Paranoid features have also been found in more muscular physiques. Delinquents as studied by Sheldon, the Gluecks, Epps, and Parnell frequently may be found in the "Northwest" or Mf types.

The work of Parnell provides additional quarters in the expanding House of the Constitutionalists with more blueprints in the offing.—EDWARD A. HUMPHREYS, M.D., Bureau of Mental Health Services for Children, Department of Public Welfare, Harrisburg, Pa.

PSYCHOLOGICAL PROBLEMS IN MENTAL DEFICIENCY

By Seymour B. Sarason and Thomas Gladwin

New York, Harper & Brothers, 1959, 678 pp.

Research with the mentally subnormal individual is important, Dr. Sarason says, "not only because of what we may find out about him," but also (and equally important) "because of what we may discover about ourselves and our society."

The research anthropologist, Sarason insists, as well as the psychologist, sociologist, or psychiatrist, needs to study the mentally subnormal individual in order better to understand the nature of man and culture, "not only man in the American culture, but man in the myriad cultures in which he is found." We need to know, he says, with respect to comparing an individual's behavior to certain norms, what the answers are to such questions as the following: How did psychological and cultural factors interact to produce the individual's behavior, and how representative is this constellation for the group on which the norms were based?

Part II of this book is devoted to a review of the research on psychological and cultural problems in mental subnormality. "The whole question of how much anxiety is generated in the perception by a retarded child of one test as against another has been almost completely neglected. Attention has, instead, been devoted to the appropriateness of content (e.g., verbal versus performance tests) and to a comparison of scores on tests and subtests, as though each of these scores reflected capability irrespective of differential anxiety and attitudes." The authors conclude this particular part of their discussion with the following statement: "It is certainly clear that in its present state of development, psychological testing of retarded children contributes little either to our theoretical knowledge of the problem or to their personal dilemmas. Perhaps if we explore the emotional impact of various tests as such on retarded children this situation will improve."—W. CARSON RYAN, PH.D., University of North Carolina.

AN EXPERIMENT IN MENTAL PATIENT REHABILITATION

By Henry J. Meyer and Edgar F. Borgatta

New York, Russell Sage, 1959, 114 pp.

This project, designed to study the process of rehabilitation of the psychiatric patient according to "a controlled group design," was financed by the Russell Sage Foundation. The agency undertaking the program under study was the Altro Health and Rehabilitation Services Inc. The workshop used for the study was engaged in the manufacture of nurses' uniforms and hospital gowns which were sold on the competitive market. The research design included two groups: the first designated as "experimental" and the second "control." The study, therefore, afforded only a comparison of the group that had been in touch with Altro and others who had the ordinary experience after being discharged from the hospital.

In the selection of cases, voluntary referrals were preferred, and "authoritarian" methods of referral were discouraged. Criteria for selection were age (20–40 years), residence (the Bronx), diagnosis (dementia praecox), no previous admission to the hospital, duration of hospital residence (three to twenty-four months). The delay in transferring records from the hospital to the Altro project was a serious handicap and there was a significant loss of cases at the

screening level caused more by their unavailability than by their unsuitability. A tightening-up of procedures failed to bring the expected number of clients into the program. From October, 1955, to July, 1956, there were 39 cases screened, of which 19 were selected, and of this number only 4 entered the project. In 18 months, only 10 out of 35 of referred patients reached the workshop. Failure was explained by the late approach made to patients and by viewing the situation from a standpoint of the practitioner rather than the object of his practice. Furthermore, the experience reported suggested that the operation of agencies required study perhaps as much as the clients they sought to serve.

The study attempted was probing a most difficult and challenging area of interest, one involving some very subtle factors. One factor, for example, is the attitude of the patient toward his hospitalization. This has broad subtle implications. The admission of a person to a state hospital still has a stigma attached to it. This stigma makes itself felt most, obviously, by the person himself. Consequently, he is often—and it may be more than often—quick to sever himself from any association or connection with the mental hospital. It is clear that the coordination between the after-care clinic and Altro, specifically the interviews which constituted the referral, could impress the convalescent patient with the idea that Altro was, in effect, an extension of the painful and stigmatizing experience which the patient may have been eager to cloud in memory.

Early in this report, reference is made to transitional employment as a means of rehabilitating the patients. Later, repeated reference is made to the patients in Altro as having entered treatment. This raises some question as to whether the goals for the patient were clearly defined or whether there prevailed an attitude which saw the persons in the project as *patients in treatment* rather than as *persons in rehabilitation.*

The reluctance of the case workers "to pursue" those persons not seeking the assistance of Altro is certainly justified. They had more experience in this kind of follow-up than the other personnel. Indeed, the study was not intended to include research on the "untested hypothesis" (mentioned on p. 29) of whether or not persons not actively seeking help can be helped. There is, actually, no clarification of the role of the after-care social workers and that of the Altro caseworkers during the period of convalescent care. Were they collaborating, or were they working in parallel, or did the after-care social workers withdraw after the referral to Altro?

The suggestion that the operations of social agencies may need study, and particularly the argument that the clientele of an agency may represent only those who get to the agency rather than the most needy, are both open to speculation regarding their pertinency. There is a teasing thought that the authors, in their frustration, may have extended themselves a bit too far in seeking to explain the lack of more positive results in the study. There are too many other factors to be investigated and clarified, such as the patient's attitude toward his hospitalization, the attitudes of the Altro personnel toward the convalescent person, the validity of limiting the Altro candidates to schizophrenics, the value of the experience of the psychiatric social workers (who do a certain amount of individual rehabilitation in their own right), and other factors which could be listed. It is suggested that much more preliminary study and research than was originally envisioned might be in order in any future study along the lines followed in this project.—MILTON E. KIRK-

PATRICK, M.D., Monmouth Medical Center, Long Branch, N. J.

THE CHILD: DEVELOPMENT AND ADJUSTMENT

By Max L. Hutt and Robert Gwyn Gibby

Boston, Allyn and Bacon, Inc., 1959, 401 pp.

Why do babies differ in emotional responsiveness? What makes some children characteristically sad, while others are characteristically happy? Why are some pleasant, while others are hostile?

These are three of the many questions with which Hutt and Gibby introduce their comprehensive volume on child development. The authors have sought to organize their discussions around "the central unifying theme of the child's personality." It is amazing how growth occurs, they say.

"What forces are responsible for the incessant growth movement onward and upward? Why do certain stages in the child's physical and mental development occur in particular sequence? Why, despite all of the fascinating and intricate differences among human beings, are there so many fundamental constancies?"

Enough studies have now been made, they say, to make some definite statements about child development and behavior:

"All behavior is motivated; that is, all behavior is based on the underlying needs of the individual. A person is born with certain innate, biological equipment. At birth, people differ in weight, length, complexity of nervous system, color of skin, type of blood, and so on. However, they are all born with the same types of basic drives (sometimes called instincts). These original drives constitute the raw material of human nature."

What is a healthy personality? The authors prefer a positive approach: "For our purposes we shall consider the healthy personality as that which is able to provide adequate satisfaction of an individual's basic needs, while, at the same time, enabling the individual to meet the demands of his society in a pleasurable and competent manner." And they add: "This conception of the healthy personality is a dynamic one; it assumes that personality is healthy when there is a give-and-take and a constant interaction of the individual's needs and the needs of society. The healthy and mature personality strives constantly to balance inner needs with external realities in a manner that takes both into account and finds a stable but constantly varying pattern of response."

Considerable discussion in the book is given over to the schools and their effects on children. The authors are careful to say that school will not *produce* a new personality, but it may strengthen trends that already do exist and weaken others. "Its potential influence is enormous, in the subsequent effects upon the society of which these children will be a part, as well as upon the children themselves." The authors stress particularly the "atmosphere of the school class," citing as part of the evidence the famous Iowa studies of some years back.

Special mention is made in the article of the present-day child guidance clinics with their resources for evaluating a child's needs and possibilities:

"The child-guidance clinic can evaluate a child's mental capacities, personable characteristics, special interests and aptitudes, educational achievement and disabilities, and physical and neurological deficiencies. It can offer individual and group treatment to the child or his parents as it is needed. It can act as a resource agency for general consultation and advice for school personnel. Because it is 'right on the spot,' it

can often help to prevent a relatively mild problem from becoming a more serious one."—W. Carson Ryan, Ph.D. University of North Carolina.

LOVE AND CONFLICT: NEW PATTERNS IN FAMILY LIFE

By Gibson Winter

New York, Doubleday & Co., 1958, 191 pp.

Dr. Winter addresses himself to families with growing children, to husbands and wives who have marital problems, and to families who are concerned about their older relatives.

The book is organized in eight chapters entitled: "Emergence of the New Family," "Cold War in the Family," "Father in Fact," "The Covenant of Intimacy," "A Time to Love," "Youth in Transition," "From One Generation to Another," and "Time for Intimacy."

Dr. Winter has great concern for people, and in everything he says, he is inspired by his own deep religious convictions. His professional background is that of an ordained minister and, in his pastoral work, he had become aware that he did not quite understand the thinking and feeling of the young people he was working with. This led him to the study of social sciences.

In his book, Dr. Winter describes, in a popular and understandable manner, the effects of our technological civilization on the values of our society. His thesis is that the family is uprooted and deprived of most of its influence. This he considers an evil of immense consequence. But he admits that one cannot reverse the course of a development of such scope. The turn of events leaves the family with one prominent function: to satisfy the individual's need for intimacy. In our depersonalized civilization, intimacy cannot be found anywhere else. Yet, to maintain the functioning of the family, changes are necessary. It is at this point that the inconsistencies of the book come to the fore. The author states that we cannot turn the clock back, but that there is the necessity for leadership and authority in the family. He regrets the fact that in the American family, authority has shifted from the father to the mother and the children, but he is convinced that this will not do. The author earnestly suggests the re-instatement of the father in the position of leadership. He refers to the Bible which speaks of the authority of the husband over the wife in the marriage relationship, and he makes it clear that he believes that "the Bible provides the touchstone by which to test new developments."

Dr. Winter has read and quoted from a goodly number of the more important recent sociological books which bear on today's family situation, but he finds the answers that are satisfactory to him in the Bible. There should be no quarrel with this as long as the approach is openly declared as pastoral rather than as the integration of pastoral and sociological concepts.

Many students of family life will not go along with Dr. Winter's deep conviction that the father must be the leader and the aggressive one in the family and that the woman's role is to accept and to receive. They might be inclined to believe that in our society there is no clearly cut pattern for family life and that each family is unique and has a right to set realistic goals for itself. Each family member will work towards these goals in his own characteristic way. Leadership might change according to the particular problem a family is confronted with at any given time and, hopefully, there will be interdependence and a

certain amount of dependence among the family members.

The family has gone through many a crisis, has lived through war and peace and, so far, has been able to stand up to everything. I agree with Dr. Winter that we have good reason to believe that the family is here to stay, not because it fits our author's religious beliefs, but because the family is an inherent element of life's sociological structure.—MRS. ELSE SIEGLE, Community Service Society of New York.

CHILD-CENTERED GROUP GUIDANCE OF PARENTS

By S. R. Slavson

New York, International Universities Press, 1958, 333 pp.

Mr. Slavson always writes in an interesting manner, and this book is no exception. Despite all the careful distinctions made between group therapy and group guidance, group guidance is a form of group therapy.

In group guidance, "the aim is to affect specific attitudes which do not proceed from strong neurotic conflicts and compeling needs to behave in a particular manner; rather the behavior is a result of misconceptions of what the function of parenthood is, what the parent's role is in the development of the child, and of the rather universal lack of knowledge or misunderstanding of the needs of young children." Mr. Slavson discusses this in great detail and with many case illustrations. He reviews how parents learn to be parents and better understand their children; also, how family tensions are eased. Mr. Slavson carefully reviews the pitfalls when the group is led to deviate from its primary aim or when the leader, in demeanor or by error, threatens the group's existence. In his criteria for careful selection, he emphasizes the basic requirement for inclusion of parents—that the child must not be a part of the parent's neurotic syndrome. The chapter entitled "The Dynamics of Child-Centered Group Guidance of Parents" is very interesting and well worth special study, and there is a chapter with a careful discussion of the relation of group guidance to group psychotherapy. The aim of child-centered guidance groups is not to acquire insight but rather to sensitize parents to their children and help them understand their needs.

I think Mr. Slavson is stretching a point in considering training for parenthood as essential as training for engineering or nursing.

"Empirical training on the job is the only road to skill. There is no reason why the same principle does not apply to the skills of parenthood he says."

That's a tall order, as all know who work in parent education, but it's probably because "appropriate action can be learned only through guided action which these child-centered parent groups supply." I wonder.

I'm sure that in skilled hands like Mr. Slavson's, the careful focus of the group discussions could be maintained as "guidance" rather than more formal "group therapy," and a selection of "normal and healthy parents" could be obtained. Group guidance in the hands of those not as superbly skilled as Mr. Slavson could wreak havoc, as I have repeatedly seen. This is an interesting book, and it is to be hoped that group leaders will undertake to learn thoroughly their role and the principles of group selection for guidance. This book will help them to be exacting in their functions.—JOSEPH D. TEICHER, M.D., Child Guidance Clinic of Los Angeles.

MENTAL HEALTH AND HUMAN RELATIONS IN EDUCATION

By Louis Kaplan

New York, Harper & Brothers, 1959, 476 pp.

Schools must educate for mental health, as well as for knowledge and skills, Kaplan says in this valuable book on mental health and education.

Considerable attention is given in the book to the nature and extent of psychological disorders as a preliminary to detailed accounts of mental health programs in schools and communities. A section dealing with "environmental influences on personality" treats of psychological forces in the home, patterns of parent-child interaction, disciplinary practices in the family, and social-class influences on mental health. There is a comprehensive section on "better understanding of child behavior."

That schools have an essential function with respect to mental hygiene is stressed throughout the book. The schools must, Kaplan says, educate for mental health, "so that youngsters will learn to work together in wholesome and satisfactory ways and develop the capacity to live with themselves and with other people as mature and responsible citizens."—W. CARSON RYAN, PH.D., University of North Carolina.

REVOLVING DOOR: A STUDY OF THE CHRONIC POLICE CASE INEBRIATE

By David J. Pittman and C. Wayne Gordon

Glencoe, Ill., The Free Press, 1958, 154 pp.

This book is remarkable, not so much for its actual content, but as an indication of the new force in the attack on such perennial American social problems as destitution, alcoholism, and jails. As to its actual content, the authors, both sociologists, show that nearly one-half million Americans are caught in the vicious circle of poverty and drinking, are arrested and jailed and then released to the same chaotic social conditions which, in turn, lead to further incarceration. Hence, the term "Revolving Door." The writers demonstrate that these men fail in whatever they attempt to do, be it in school, work, or marriage. Of the greatest significance is the theme of "undersocialization," that is, the failure in their interpersonal relationships, a theme which runs through their entire lives and is probably related to their early parental deprivation.

As mentioned above, it is not the content that bears the greatest significance, for these facts have been understood for some time. The real meaning of this book lies in the authors' recommendations. Instead of jails, which they condemn as futile, they suggest the erection of therapeutic centers and halfway houses staffed by social workers, psychologists, and psychiatrists. These suggestions they consider "radical," but in recommending them, the authors represent a new force, in the sense that as social scientists, they step beyond their scientific roles into the broader and less clearly defined fields of the penologist, the politician, the judge, and the clinician. They become reformers and hence part of a wonderful and old American tradition that continually strives to improve the lot of the poor and the sick.

Yet the authors fail to convey sufficient conviction, perspective, and zeal, all of which are implied in the potent word "radical." I can hardly imagine that any legislator who reads this book will be willing to spend millions of dollars for this group of failures. Furthermore, I doubt if the writers have enough facts and experi-

ence to warrant these costly changes. While I do not disagree with their recommendations, I suggest that a great deal more experience and research from all disciplines be accrued in this complex field which extends beyond the realm of the social scientists or the clinician and into the non-scientific disciplines of history, politics, and the law. Although radical changes are sensational, those who are aware of these complexities realize that progress, to be effective, must proceed step-by-step with the pace of knowledge.—DAVID JOHN MYERSON, M.D., Brookline, Mass.

THE PSYCHODYNAMICS OF FAMILY LIFE: DIAGNOSIS AND TREATMENT OF FAMILY RELATIONSHIPS

By Nathan W. Ackerman, M.D.

New York, Basic Books, Inc., 1958, 379 pp.

This book is a plea for a larger recognition of the role of the family in mental illness. "Mental illness limited to a single member of a family group," says the writer, "is a rarity." On this account and others, he proposes the treatment of the family as a unit. This requires him to develop, in Part 1, a set of concepts for understanding family interaction, and, in Part 2, some clinical aspects of family diagnosis and some special techniques of family diagnosis. These favor the use of clinical teams and home visits. The treatment of dyads, triads, and the like require new methods intermediate between those of classical psychoanalysis (which limits interviews to the patient) and group therapy.

The underlying thesis is that sick individuals come from sick families. Even if this thesis is accepted, there are two further considerations. Sick families may come from sick societies. And even if not, families may have connections with employers, co-workers, friends, co-religionists, and others who contribute to the mental illness of family members. The whole society is too big a unit for therapy and is more appropriately a target for reform. If the psychotherapist limits his therapy to the family, how does he deal with these "significant others," these significant outsiders who are involved in the web of family relationships? And how is family therapy to be used in our highly mobile society when the members of the family are scattered?

Students of the family will be grateful to Dr. Ackerman for increasing our awareness of the role of the family in mental illness. The question remains as to whether family therapy is superior to the traditional method of individual therapy. Perhaps each method has advantages for certain situations or under certain conditions. More knowledge is needed. The issue is one to be determined by research, not by argument, as Dr. Ackerman recognizes in his penultimate chapter.—M. F. NIMKOFF, Florida State University.

THE SOCIOLOGICAL REVIEW MONOGRAPH, NO. 1

Papers on the Teaching of Personality Development

Introduction by K. Soddy

Keele, Staffordshire, England, University College of North Staffordshire, 1958, 138 pp.

The nine papers which form this volume were originally presented at a conference on "The Problems Arising from the Teaching of Personality Development to Students of Education and Social Work" held at the University College of North Staffordshire. Although only 30 participants were expected

when the conference was planned, there were 187 registrations. The published papers suggest that the conference was well worth the interest it generated. The conference was arranged by P. Holmes. Other contributors include W. A. C. Stewart, F. E. Waldron, E. M. Oakeshott, K. M. Lewis, B. Morris, E. J. Shoben, Jr., A. H. Ilffe, and R. Wilson.

A recurrent theme in the monograph is the importance of insight into personality development for students and professional personnel in all fields dealing with human welfare. While teaching and social work receive primary attention, the discussions are equally applicable to medicine, nursing, law, and other service professions. Most of the contributors stress the importance of self-knowledge if one is successfully to achieve insight into the problems of others and attain that balance between identification which helps one to understand and appreciate the other's problem and objective detachment which makes tolerable and effective a therapist's role.

The volume reflects a psychoanalytic orientation of several of its contributors. Yet major emphasis is on the contributions of psychoanalytic theory to the understanding of behavior, and there is also a broad orientation to behavior theory with psychology depicted as playing only a part in the search for a more holistic conceptualization. Language, intelligence, learning mechanisms, culture, genetic factors are all discussed. For this reviewer, a highlight of the volume is found in E. J. Shoben, Jr.'s (pp. 102–3) neat discussion of his approach to behavior theory.

"It is highly probable that the various forms of psychoanalysis, phenomenological ideas, and reinforcement theory all possess snippets of truth, but that none has a monopoly on it. Consequently, there is a danger of real intellectual bigotry in converting these theoretical systems into ideological banners and endowing them with the status of schools to be defended or positions to be fought for. They are simple tools of thought, and in our professional enterprise, the more such tools we have, the better. To argue this case is not, of course, to plead for an eclecticism that sloppily accommodates contradictions. Rather, it is to urge that the various theories be closely examined for genuine issues . . . and, . . . that they be systematically read for what they can suggest to the student about himself, his relationships, and his real or potential clients."

In general, the volume does not present new or unusual ideas, but its messages are clear and refreshing. There is also an excellent 113-item bibliography.—ROBERT STRAUS, PH.D., University of Kentucky.

PREPARATION PROGRAMS FOR GUIDANCE AND STUDENT PERSONNEL WORKERS

By Paul MacMinn and Roland G. Ross

Washington, D. C., Government Printing Office, 1959, 49 pp.

(U. S. Department of Health, Education, and Welfare, Bulletin, 1959, No. 7)

How far have we progressed in the preparation of guidance officers and other personnel workers in the schools? This is the question the authors attempt to answer.

At least 223 institutions of higher education, the authors report, have a "preparation" program at the graduate level for guidance and student personnel workers. "Counseling" is the course required by most of the institutions reporting (93 per cent), with "Analysis of the Individual" next (91 per cent). A course in "Psychological Foundations" is required in 70 per cent of the

institutions, and 17 per cent require "Sociological Foundations." At the doctoral level, "Methods of Research" is required by all the institutions, with counseling, analysis of the individual, the "practicum," and "psychological foundations" following closely.

As to personal qualifications for counseling, the authors say: "There is agreement that personal qualifications should be a factor in the admission procedure, but the difficulties involved in objective measurement make this one of the most perplexing areas to evaluate. When this factor is assessed, it is done usually through 'committee screening,' 'interview,' 'recommendations,' or methods which are identified as subjective evaluation." Two institutions, however, reported the use of the Minnesota Multiphasic Personality Inventory as a screening device for ascertaining personal qualifications.—W. CARSON RYAN, PH.D., University of North Carolina.

READING IN SOCIAL PSYCHOLOGY, Third Edition

Editorial Committee: Eleanor E. Maccoby, Theodore M. Newcomb, and Eugene L. Hartley

New York, Henry Holt & Co., 1958, 674 pp.

The third edition of *Readings in Social Psychology* is a welcome event to behavioral scientists in general and to people in the mental health professions in particular. Sixty-two articles, with topics ranging from social perception and communication to role conflict, intergroup tension and social stratification, provide the reader with an idea of the current spectrum of significant research in the broad field of social psychology.

As the three editors note in their preface, "This edition carries even further the empirical principle adopted in the two previous editions," and they "elected to concentrate heavily upon" research reports rather than on articles of more theoretical nature. This reviewer recognizes the predominance of tight experimental and quantitative studies as an integral aspect of contemporary work in the behavioral sciences. Nor is he alone in finding that the pervasive application of statistical rigor, of mathematical model construction, and the associated replacement of longitudinal and cross-sectional interview and observation methods by inventory, questionnaire and polling techniques have not been an unlimited blessing. Most observers of the social science scene agree that this has not necessarily resulted in a significant increase of basic insights in or the development of new concepts on the socio-psychological behavior of man.

In line with this present-day trend, this volume accurately reflects the rapid growth of research efforts committed to the discovery of "developmental" rather than original or unique interpretations and findings in the course of government- or foundation-sponsored study projects. Also, this volume correctly mirrors the current dominance in socio-psychological research of the "integrative" concepts of social perception and role. Whether the expanded use of these concepts, often in apparent definitional isolation from others like motive, commitment, intent, situation, and actor, will become as obsolete a conceptual style as did the notions of instinct and attitude, remains to be seen.

In the light of these impromptu reflections on the field of social psychology, this reviewer, like the editors, feels "much more satisfied about the inclusions than about the omissions in this volume." However, the articles selected for this volume are, on the whole, readable and not over-technical. They will, without question, provide valu-

able resource material and stimulating leads to all mental health professionals engaged in furthering their understanding of the normal and deviant patterns of the functioning of man as a social animal.—OTTO VON MERING, M.D., University of Pittsburgh.

THE EMOTIONAL CLIMATE OF OUR TIMES

By Bernice Milburn Moore and Harry Estill Moore

Austin, Tex., The Hogg Foundation for Mental Health, 1959, 11 pp.

In this comparatively small pamphlet, the Moores have put together some striking statements of unusual significance for mental health. On the one hand they describe vividly the insecurity in the world today—"knowledge that an intercontinental missile requires less than three hours to deliver in one blast more devastation than all the bombs dropped by all the planes in World War II." Ours is "the Era of the Great Doubt, often accompanied by the Great Fear." We are persons in a world afraid, "a world in which there is magnificent promise overshadowed by the peril of total destruction."

On the other hand, there is tremendous promise for man "in the concepts of configuration, of unity, of purposeness in the universe," and there are specific types of evidences for the future: "Husbands and wives, mothers and fathers, are rearing their children, developing their homes, making their decisions, and, in many instances, earning their family living as partners" and, in spite of the current popularized attack on "togetherness," a new unity and strength in the family appears to be near achievement.

Of special importance, the authors say, is the role of education today; "Education, at home in the family, at church in the congregation, and at school in the class, is being geared to the development of normal and healthy personalities." On the other hand, we have seemed reluctant to put into use what we know—particularly in the behavioral sciences:

"Even at this moment there seems to be a growing tendency to attack these same sciences and their research and clinical findings through the demand by a highly audible minority for the back-to-woodshed concept of physical punishment as the road to self-discipline; the return to fear and force as the way to control men who differ in opinions on social problems; the abandonment of education in human relations by business and industry as "too soft" an approach to problems between persons; the return of women to a subservient relationship with men through reiteration that today's women are demasculizing or even killing the men of the nation in their new roles as co-equals."—W. CARSON RYAN, PH.D., University of North Carolina.

PATIENTS, PHYSICIANS AND ILLNESS

Source book in behavioural science and medicine

E. Gartly Jaco, Ed.

Glencoe, Ill., The Free Press, 1958, 600 pp.

Deplorable side effects of the development of medicine as a biological science and of the brilliant discoveries in laboratory research have been a fragmentation of the patient into laboratory artifacts, and increasing specialization in the practice of

medicine, and a fragmentation in the physician-patient relationship. Countermoves aimed at restoring consideration for the total patient, i.e., the whole person with a disease rather than the disease process itself, have been the emergence of the concept of psychosomatic medicine and, more recently, the introduction of the behavioral sciences to medicine.

As the editor points out in the introduction, the contents of this book are offered as a source book of representations of the type and extent of the efforts and thoughts of behavioral scientists and medical men attempting to expand the horizons of medicine. Fifty-three of the 63 contributors are behavioral scientists, and the remainder, physicians. Of the 55 chapters, 20 have not been published previously. The chapters are grouped into seven sections each of which is preceded by a brief synoptic passage written by the editor.

A review of a book of this magnitude can obviously not do justice to the galaxy of its contributors and the wealth of their contributions. A brief summary must suffice.

The first section has been divided into two major parts of which the first deals with social epidemiology and the second with social etiology, i.e. the connection between conditions of social stress and the onset of illness. Subjects presented include the relations between socio-economic status and chronic illness.

Experimental studies indicate a significant relationship between church attendance and stress reactions affecting the cardiovascular system. The concept of "sociosomatic" illness as an extension of the psychosomatic concept is proposed.

The second section headed "Health and Community" deals with studies of those conditions to which individuals are exposed and which, in turn, bring about disease itself, such as the existence of sanitary health practices, poor dietary habits, ignorance of preventive health techniques and practices, and laxity in obtaining proper medical treatment because of a failure to recognize symptoms of illness. It is shown that the social class of the population affected by certain diseases is a factor that very often stimulates medical research towards the controlling of that disease, that cultural biases of dietitians and nutritionists may interfere with successful introduction of nutrition programs, that the community power structure affects the outcome of community health programs and that the concepts of health and illness depend on cultural values and the social structure of American society.

The third section deals with the impact of culture upon the process of medical care and treatment and upon societal attempts at healing of a non-medical nature. Discussed are: folk and primitive medicine, some aspects of the patient-physician relationship, normative components of certain hygienic practices in a tuberculosis hospital, and the relation of changes in the American family system to some socio-cultural and social psychological aspects of illness and treatment.

The patient as "a person with an illness" is covered in the fourth section which deals with such subjects as the sick person's orientation in the hospital, differences in response to pain-experience by sub-cultural groups, management problems in Christian Scientist patients, and motivation for turning to quacks in patients suffering from cancer.

The fifth section is devoted to the social process of medical education and its impact upon the student-physician, to the various phases of development confronting the physician as he passes from his premedical training to establishing his practice, to transformations of personality characteristics of

medical students in a medical school, to differences between the clergy and the medical profession as they affect medical education, to the process of professionalization of the physician, and to medical education as a distinct social process.

"Healing Practices and Practitioners" is the heading of the sixth section. It includes chapters on: specialization in medical practice, factors that develop good doctors, factors involved in malpractice suits, the interrelationship between surgeons and their patients in a teaching hospital, the significance of the cultural environment of patients for the practicing pediatrician, the problems of the osteopath, and the consequences of socialized medicine in England.

The seventh and last section of the book concerns itself with a special realm of investigation by behavioral scientists—the medical setting: hospital, clinic, and office. Chapters in this section deal with the social structure of hospitals, hospital ideology and communication between various categories of personnel, differentials in organization, staffing and operations between public-supported and privately-operated mental institutions, the effect of the status system of an out-patient psychiatric clinic upon patient care, and the financial aspects of medical practice.

This is an important book, very much worth reading. It suffers, as do all books of this kind, from the inevitable spottiness and lack of cohesion of different authors. At times the data presented in individual chapters become too technical for a reader not fully acquainted with the specific discipline, but even if some areas are outside the scope of a reader, rather like in a good variety show, there must be many others which appeal to his taste.

The selection presented serves its purpose of showing, in a kaleidoscopic view, representative efforts by behavioral scientists and physicians in the study of the social aspects of illness and the practice of medicine.—E. D. Wittkower, M.D., McGill University.

Notes and Comments

MENTAL HEALTH MONTH ACTIVITIES

Operation Friendship, the program initiated last year to attract visitors to the nation's mental hospitals, was repeated during Mental Health Week in May. Early reports indicate that the campaign was an outstanding success. Mental health organizations across the country cooperated in this and other diverse Mental Health Month activities. The month-long Bell Ringer Campaign for Mental Health was marked by an unprecedented number of volunteers aiding in the annual fund-raising effort of the NAMH and its affiliates.

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CARE AND TREATMENT

The Veterans Administration is engaging in a series of new care and treatment programs.

One such program, the "night hospital," is specifically designed for veterans in the last stage of recovery from mental illness. These veterans check into wards of VA psychiatric hospitals at the end of a day's work. They receive drugs or other treatment and the next morning receive a pass from the hospital and leave for another day at their jobs. Patients for the night hospital are carefully selected by VA medical staff members to fit the treatment to the needs of the veterans and to protect employers and the community. Only those who have shown they can accept responsibility and make good employees are chosen.

The VA has also established five "day centers" to provide a means of therapy that is intermediate between full-time hospitalization and the types of therapy available in the conventional mental hygiene clinic. A typical week's schedule at a day center includes two periods of group psychotherapy, music therapy, games, crafts, movies, a library period, current events discussions, an open house for the patients' friends and relatives and daily conferences between patients and staff members.

A program designed to best assure aspects of individual dignity and self-respect among older, incapacitated veterans is also being conducted by the VA. Participating are the 16,000 disabled veterans who are residents of the VA's 18 domiciliary homes. The program includes psychological testing and interviewing to learn the individual's recreation and work interests. Many engage in machine shop work and clerical tasks. The new program is aimed, according to the VA, at preventing the aging veterans from "drifting aimlessly into inactivity and physical and mental degeneration."

VA Administration mental hospitals are putting the families of patients on the hospital team. At the Lexington, Ky., VA hospital, for example, there is a successful new method carried out by the patients themselves. They call it "Family Acquaintance Day." With the active encouragement of hospital officials, the 74 patients of one ward invited their families to come to Lexington and spend a whole day, seeing at first hand the life the patients lead in the hospital. The hospital reports that "the results were beyond expectations." More than 150 visitors came, a total of 50 families of patients, some traveling as far as 800 miles.

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The Government of Saskatchewan has announced that it will begin the construction of a community psychiatric center at Yorkton within a few months. Since the setting up of a Psychiatric Services Branch within the Saskatchewan Department of Public Health in 1946, a series of changes have

been brought about which have drastically altered the prospects of the province's mentally ill.

The development of an active treatment program in the mental institutions has been brought about by building up a well-trained professional staff oriented to treatment and rehabilitation. In 1947 a three-year training program for psychiatric nurses was instituted; a training program for psychiatrists was also established; social service departments have now been developed in each institution.

Another area in which striking changes have taken place is in the extension of psychiatric service into the community. At present, a large proportion of the people of the province are within reach of consultation and diagnostic services in mental health and nearly half the population within reasonable reach of treatment services. The fact that all mental health services provided by the Saskatchewan government are completely free of charge to the people is an important factor in encouraging them to seek treatment promptly.

The regional psychiatric center, to be built on the grounds of the new Yorkton Union hospital and integrated with it, will have an in-patient section of 150 beds. It will also provide out-patient services, day-hospital and night-hospital care as required and community services throughout the region.

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LEGISLATION

The House of Representatives has voted to appropriate $79,863,000 for the 1961 budget of the National Institute of Mental Health. This is $12,300,000 more than the total proposed by the President and is an increase of $11,898,000 over the 1960 NIMH budget. The figure voted by the House includes provisions for $7,208,000 more for research over 1960 and $2,650,000 more for training programs. The appropriations measure now goes to the Senate.

The increased funds voted for research include $1,500,000 for further intensive studies in the field of psychopharmacology. Other increased research funds are designed for studies on the basic mechanisms whereby the psychoactive drugs have their effect, on metabolic studies on naturally occurring neochemical substances which influence activity of the nervous system and on fundamental neurophysiological research projects.

The increased funds in the area of training provide for continued psychiatric training of general practitioners and expanded programs of psychiatric education in the nation's medical schools. The House also provided $5,557,000 to continue the adjustment of starting dates of training grants. Approximately $1 million of the increased funds allotted for both training and research programs was designated for new programs and activities aimed at solving the problem of juvenile delinquency. Last year, at the request of a House committee, the NIMH took the lead in conducting a thorough study of what can and should be done in this area.

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The Health and Safety Subcommittee of the House Committee on Interstate and Foreign Commerce has unanimously approved establishment of an Office of International Medical Research in the Department of Health, Education and Welfare with $10 million authorized annually for international cooperation in health research and training.

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The Senate Subcommittee on Problems of the Aged and Aging have released a report

presenting detailed findings on the needs of America's elderly citizens, with recommendations for legislative action. The Subcommittee findings are based on data compiled from evidence gathered at hearings held in Washington and in seven cities across the nation, personal visits to representative facilities for the aged, an intensive survey conducted by the Subcommittee and extensive staff studies and analyses of programs and problems.

The report deals with many problems of the aged including health status. Individuals who are mentally ill primarily because of aging constitute about one-third of the admissions to the nation's mental hospitals and about 15 per cent of the patients in these hospitals.

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A report which the *New York Times* described editorially as "an important contribution to the public understanding of the farm labor problem in all of its complexities and also of the ways in which it is being dealt with" has been published. Its title is *The Position of Farm Workers in Federal and State Legislation* (New York: National Advisory Committee on Farm Labor, 112 E. 19th St., 1959).

The section on children states that "children of migrant agricultural workers suffer from all the disadvantages and disabilities that handicap the whole migrant community—unusual health hazards, inadequate food and housing due to low income level, lack of stable family life, and rejection by the community in addition, two aspects of the migrant situation particularly affect the children and their future. The first is the common use of child workers, both legally and illegally. The second is their deprivation of such educational opportunities as would enable them to make their own lives an improvement over those of their parents."

The report concludes that "legislation might be most beneficial in providing funds for schools in migrant areas that need additional facilities and trained teachers to care adequately for the children who travel with the crops."

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The Medical Officer, a London journal for medical men and women in the government and municipal services, recently published some mental health statistics that its readers "may find useful when it comes to addressing the local Rotary Club or even trying to persuade a reluctant chairman of a Finance Committee to look again at the mental health budget:"

1. "If we include mental patients occupying beds in general hospitals, about 45 per cent of the staffed beds in the country [England] are allocated to the mentally sick.

2. "For every 100 patients in middle life on the general practitioner's list, about 25 consult him at least once a year with some form of mental disorder.

3. "About one in every 10 persons incapacitated for the purpose of sickness benefit on any given day are suffering from a mental disorder;

4. "Since 1951 the number of first admissions to mental hospitals has increased by 25 per cent and the number of readmissions has nearly doubled.

5. "At any given time about one per cent of people aged 65 and over are resident in a mental hospital;

6. "It can be estimated that mental illness costs the country directly or indirectly about one million pounds per day."

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MEETINGS

The Sixth International Congress on Mental Health will be held at the Sorbonne in

Paris from August 30 to September 5, 1961, under the auspices of the World Federation for Mental Health. The Congress will be open to professional workers in psychiatry, psychology, education, nursing, social work and allied fields and to non-professional people interested in the promotion of good mental health and human relations throughout the world. Requests for further information should be addressed to the World Federation for Mental Health, 162 East 78th St., New York 21, N. Y.

* * *

Horizon House, Inc. (formerly Foundation House, Inc.) held its eighth annual community meeting in May in Philadelphia. Walter A. Munns, president of Smith Kline & French Laboratories, made a plea for broader state and private care for released mental patients. He said that "aftercare is today a public health problem and, as such, not only requires broader public support to finance new clinics and the necessary professional staff but also a cooperative effort by all these involved—private agencies like Horizon House, the mental health associations, the medical and pharmacy professions, the drug industry and the state legislature."

Munn received the first annual Edward A. Strecker medal on behalf of the ethical drug firm he heads. The award was presented "for outstanding service in the field of psychiatric aftercare."

Dr. Margaret Mead also addressed the annual meeting. She called for "an all-out attack on mental health problems" and urged the establishment of community clinics for early diagnosis and out-patient care.

Dr. Irvin Rutman, executive director of Horizon House, told the meeting participants that more than 600 former mental patients had come to the center for assistance since 1953. "In the course of an average month," he said, "approximately 750 visits are made to Horizon House by about 150 former patients participating in one of our programs—social readjustment, individual counseling and vocational guidance."

A study made by the organization two years ago shows that the rate of returns to hospitals among Horizon House members was about 15 per cent, as compared to the national figure of 35 to 50 per cent.

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The first national Institute on "The Total Rehabilitation of Epileptics" was held in Chicago in May. The institute was arranged by George N. Wright, Ph.D., program director of the National Epilepsy League, one of three sponsors. The others were the University of Illinois and the Office of Vocational Rehabilitation.

Dr. Wright stated that "recent study has shown that compared to other disabilities, epilepsy is the greatest block to employment. Most could become productive and valuable workers with skilled assistance from their counselors. These field workers need practical know-how in order to work effectively with epileptics and their unique job problems."

"It is our hope," he added, "that following the development of this material we will be able to conduct a series of state and regional conferences which will ultimately result in placing the rehabilitated epileptic on a payroll."

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PUBLIC INFORMATION

The *Atlanta Constitution* is the winner of the 1960 Mental Health Bell Award. This award is presented each year by the NAMH

to the daily newspaper which, during the preceding year, has made an outstanding editorial contribution to the fight against mental illness.

The Atlanta newspaper last year devoted itself to an editorial examination of the conditions at Milledgeville State Hospital, stated the reforms needed and then insisted these changes be made. Jack Nelson, the reporter responsible for the Milledgeville articles, was recently awarded a Pulitzer prize for the series.

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APPOINTMENTS

Dr. Oreon K. Timm, area medical director for the Veterans Administration in St. Paul, Minn., since January, 1958, has been appointed deputy to the VA assistant chief medical director for operations, Washington, D. C. He will assist in directing operations of the VA's 170 hospitals, 91 outpatient clinics, and 18 domiciliary homes. He succeeds Dr. Horace B. Cupp who is retiring after 30 years of VA medical service.

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Dr. Charles H. Jones, superintendent of Northern State Hospital, Sedro Woolley, Wash., has been named superintendent of Butler Health Center, Providence, R. I.

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Dr. Dale C. Cameron, a career officer of the U. S. Public Health Service from 1937–1954 and director of the Division of Medical Services, Minnesota Department of Welfare since that time, has been recommissioned in the USPHS and assigned to the National Institute of Mental Health.

Dr. Cameron has been assigned to the training branch of the Institute and, in addition, will conduct a several months' study of mental health and mental hospital programs in a number of European countries. Later this year he will be detailed to St. Elizabeths Hospital, Washington, D. C., as assistant superintendent.

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Dr. Joseph D. Teicher, director of the Child Guidance Clinic of Los Angeles, has been appointed adjunct professor of child psychiatry at the University of California School of Medicine and director of the Children's Psychiatric Services of the Los Angeles County General Hospital.

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Dr. H. Martin Engle, manager of the VA Hospital in Denver, has been appointed deputy chief medical director for the VA in Washington, D. C. He succeeds Dr. Roy A. Wolford who retired in April after more than 40 years of Federal service.

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GRANTS

A grant of $1,261,448 to the Johns Hopkins Medical Institutions to establish an extensive research program into the causes of mental retardation and to aid in the construction of a Children's Medical Center has been announced by Robert F. Kennedy, president of the Joseph P. Kennedy, Jr., Foundation.

The grant provides $1,000,000 over a period of 10 years for research into the etiology of mental retardation, including financial support of up to $15,000 annually for each of five senior research scholars; $150,000 toward the construction of ten beds and their related hospital facilities in the Children's Medical Center; and $111,448 toward the construction of a laboratory floor in the Children's Medical Center to be known as the Lt. Joseph P. Kennedy, Jr.,

Laboratories for Research in Mental Retardation.

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AWARDS

Judge David L. Bazelon of the U. S. Court of Appeals in Washington, D. C., is the ninth winner of the American Psychiatric Association's $1,000 Isaac Ray Award. This award is given annually to a psychiatrist or member of the legal profession for furthering understanding between the two professions. As recipient, Judge Bazelon will deliver a series of lectures at the University of Chicago during the 1960–61 academic year under the joint auspices of that university's law and medical schools.

Judge Bazelon has become widely known in recent years for his formulation of the Durham Decision which brought to American jurisprudence the concept that when criminal acts are perpetrated as the result of mental illness, the Court will consider the nature of the illness of the accused.

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President Eisenhower has presented "The President's Award for Distinguished Federal Civilian Service" to Dr. Winfred Overholser, superintendent of St. Elizabeths Hospital, Washington, D. C. This is the highest honor the country can bestow up its career civil servants.

Dr. Overholser was commended for his "profound and far-reaching contributions in the field of mental health."

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PUBLICATIONS

"Criminal psychodynamics," wrote Dr. Benjamin Karpman as he introduced the pages of a new journal in 1955, "has for its purpose the study of the genesis, development and motivation of that aspect of human behavior that conflicts with social norms and standards."

Until that time, a journal devoted to the psychology of crime had never existed.

Since its beginning, the *Archives of Criminal Psychodynamics* has consistently encouraged research into the psychodynamics of antisocial and criminal behavior and has pioneered in the dissemination of the resulting knowledge through its multidisciplinary approach.

Since Editor Karpman emphasizes the multidisciplinary approach, other articles not directly dealing with crime are occasionally published. Moreover, philosophical and anthropological contributions, as they relate to the problem of crime, are regularly included.

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The Citizens' Advisory Group of the New York State Association for Mental Health recently issued its annual report entitled "As Citizens See It."

The report includes a list of primary recommendations of the Group, as adopted by the state association, a summary of the proceedings of last spring's meeting of the Citizens' Advisory Group, and a comment on these proceedings by Dr. Paul M. Hoch, commissioner of the New York State Department of Mental Hygiene.

Copies of this report—small quantity orders only—are available free of charge from the NYSMH, 105 East 22nd Street, New York 10, N. Y.

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The National Health Council has published the book *The Health of People Who Work* to offer practical help for extending occupational health services. This publication is based upon the 1959 National Health Forum and concludes the first phase of the 1959 Forum Follow-up Committee's activi-

ties. Priced at $4.50 per copy postpaid the new book may be obtained from the National Health Council, Inc., 1790 Broadway, New York 19, N. Y.

This resource includes chapters on the goals of occupational health programs, the special problems of the smaller plant, the control of the working environment, the placement of workers in relation to their physical and mental capacities, health education in the occupational setting, preparing the worker for retirement, earning support for the occupational health program, and the placement of workers in relation to their physical and mental capacities.

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The Social Legislation Information Service has issued three recent reports of interest to the mental health field:

People and Homes reports on usual and new elements in the 1960 census. Those concerned with research and public and private hospital care will need the data gathered by this census. Another report, entitled *Report to Congress on Juvenile Delinquency,* is a follow-up on the request by Congress to the National Institute of Mental Health and the Children's Bureau to express their thoughts on what should be done in this field.

The third item is an after-view of the White House Conference on Children and Youth in which so much of mental health interest was brought forward.

Each publication is priced at $.25 (quantity prices upon request). Orders should be sent to the Social Legislation Information Service, Inc., 1346 Connecticut Avenue, N.W., Washington 6, D. C.

The Social Legislation Information Service is the one inexpensive way of keeping track of mental health and related activities and trends in Washington.

The first issue of *Rehabilitation Record,* a new 40-page, bimonthly periodical issued by the Office of Vocational Rehabilitation, contains 11 articles covering medical aspects, training of rehabilitation workers, blindness, older workers, state operations and research. The new publication will review activities of the Federal-State program of vocational rehabilitation, with special emphasis on research developments sponsored by the OVR.

In the article "Training Mentally Retarded for Employment," Fred A. Schumacher and James C. Townsell of the OVR describe 21 special demonstration workshops and analyze other Federal-State and private activities in the rehabilitation of mentally retarded young adults. The wide range of skilled, semi-skilled and unskilled occupations held by these young people whose conditions were once regarded as all but hopeless is also reported.

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MISCELLANEOUS

Dr. Tom D. Spies, a physician famous as a research scientist in nutrition, died in February at the Memorial Center for Cancer and Allied Diseases in New York City. He was 57. Dr. Spies was among the first to prove that pellagra was caused by a deficient diet; he was also among the first to use nucotinic acid as an inexpensive cure for the debilitating disease. At the time of his death he was professor of nutrition and metabolism at the Northwestern University Medical School.

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The integration of mental health concepts with the theory and practice of the human relations professions is the subject of a lecture program taking place between

April and November of this year. The program, sponsored by the Bank Street College of Education, is a memorial tribute to the late Dr. Ruth Kotinsky, author, educator and psychological research specialist. The lectures are being given at the Carnegie Endowment International Center, 345 East 46th St., New York 14, N. Y. Upcoming lectures will be held Saturday, September 24, Saturday, October 15, and Saturday, November 19. Time is 10:00 A.M. to 1:00 P.M. "Education" is the subject for the September lecture; "Dentistry and Nursing," the topic for October, and "Psychology and Community Psychiatry" will be discussed in November.

ARTICLES SCHEDULED FOR PUBLICATION IN COMING ISSUES OF MENTAL HYGIENE

"Some Effects of Stealing in a College Dormitory" by Paul A. Walters.

"Education's Mental Hygiene Dilemma" by Bartholomew D. Wall.

"Casework Interviewing as a Research Technique in a Study of Families of Schizophrenic Patients" by Alice R. Cornelison.

"Ethos, Existentialism and Psychotherapy" by Iago Galdston.

"Combined Individual, Joint and Group Therapy in the Treatment of Alcoholism" by Florence B. Preston.

"Transitional Programs for Psychiatric Patients" by Joseph M. Sacks.

"Controversial Issues in the Management of Drug Addiction, Legalization, Ambulatory Treatment and the British System" by David P. Ausubel.

"Suicide, Part 5" by Joseph Hirsh.

"Current Aspects of Psychiatry in Great Britain: Part 2, Recent Developments in British Mental Health Services" by H. L. Freeman and W. A. J. Farndale.

"The Main Themes of 'Existentialism' from the Viewpoint of a Psychotherapist" by Leif J. Braaten.

"Survey of Employment Experiences of Patients Discharged from Three State Mental Hospitals During the Period 1951–1953" by Samuel Grob, Simon Olshansky and Miriam Ekdahl.

"What Is a Halfway House? Functions and Types" by Brete Huseth.

"Some Observations on the Therapeutic Process in Child Psychotherapy" by J. H. Kahn.

"Psychology, Psychiatry and Mental Illness in the Mass Media: A Study of Trends, 1900–1959" by George Gerbner.

"The Extramural Volunteer" by Leon Cohen.

"Patient-led Discussion Groups in a State Hospital" by Fred Cutter.

"Criteria for Involuntary Hospitalization of Psychiatric Patients in a Public Psychiatric Hospital" by Silas L. Warner.

"The Three Worlds of the Back Ward" by Olive M. Stone.

"Recreational Preferences as Predictors of Participation in Mental Hospital Activities" by William E. Morris and Milton B. Jensen.

"Meeting the Problems of Intake in Child Guidance and Marital Counseling" by Ruth C. Oakey.

"Impact of Admission to a Mental Hospital on a Patient's Family" by Verl S. Lewis and Abraham M. Ziechner.

"An Open Service in a University Psychiatric Clinic" by Sally Dewees, Ruth F. Johnson, Saxton T. Pope and Mary A. Sarvis.

"Improving Poor Work Adjustment through Psychodiagnostic Evaluation" by Paul C. Oken and Alfred L. Brophy.

"Services Attitudes of Board and Staff Members of Community Mental Health Clinics" by Daniel N. Wiener and Allen A. Hovda.

"A Survey of Employer Reactions to Known Former Mental Patients Working in Their Firms" by Reuben J. Margolin.

"The Value of Supervision in Training Psychiatrists for Mental Health Consultation" by Beulah Parker.

"Status Stress and Role Contradictions: Emergent Professionalization in Psychiatric Hospitals" by William R. Rosengren.

"Transitional Residences for Former Mental Patients: A Survey of Halfway Houses and

Related Rehabilitation Facilities" by Henry Wechsler.

"Psychiatric Care in Transition" by D. G. McKerracher.

"Love as a Measure of Man" by Benjamin Mehlman.

"The Psychology of Democratic Freedom" by Joost A. M. Meerloo.

"The Prevention of Mental Illness" by Donald C. Klein.

"Mental Health and Group Dynamics for Discussion Leaders in Mental Health Programs" by Dell Lebo.

"Hospital-patient Relationships to Medicine and Psychiatry" by Thomas S. Szasz.

"A Survey of Vocational Rehabilitation at Longview State Hospital for 1959" by Harvey E. Wolfe.

"The Reintegration of the Chronic Schizophrenic Patient Discharged to His Family and Community as Perceived by the Family" by Eva Deykin.

"The Effects of an Activity Program on Chronic Psychotic Patients" by Margaret E. Hitt.

"Personality Disorganization Camouflaged by Physical Handicap" by Lester A. Gelb.

"A Telephone Interview: A Method for Conducting a Follow-up Study" by Catherine T. Bennett.

NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Voluntary Promotional Agency of the Mental Hygiene Movement founded by Clifford W. Beers

OBJECTIVES: The National Association for Mental Health is a coordinated citizens organization working toward the improved care and treatment of the mentally ill and handicapped, for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illnesses and handicaps; and for the promotion of mental health.

William Malamud, M.D.
Acting Executive Director